627-82153

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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ADRIAN SCHOOLCRAFT,

Plaintiff,

- against -

Case No:
10 CV 06005

THE CITY OF NEW YORK, ET AL.,

Defendants.
----------X

220 East 42nd Street
New York, New York

July 7, 2014
10:06 a.m.

DEPOSITION OF VINOD DHAR, M.D., pursuant to Notice, taken at the above place, date and time, before DENISE ZIVKU, a Notary Public within and for the State of New York.

A P P E A R A N C E S:

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JAMAICA HOSPITAL MEDICAL CENTER
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BY: GREGORY RADOMISLI, ESQ.

Also Present:

Roy Lubit, M.D.

Magdalena Bauza

S T I P U L A T I O N S:

IT IS HEREBY STIPULATED AND AGREED by and between the attorneys for the respective parties hereto, that this examination may be sworn to before any Notary Public.

IT IS FURTHER STIPULATED AND AGREED that the filing and certification of the said examination shall be waived.

IT IS FURTHER STIPULATED AND AGREED that all objections to questions, except as to the form of the question, shall be reserved for the time of trial.

MR. SMITH: Going on the record, it's 10:06 on July 7, 2014. We are at the offices of Martin Clearwater and Bell, 220 East 42nd Street. Here for the deposition of Jamaica Hospital on the policy issues identified by the court.

MR. RADOMISLI: Yes. Just a couple of things. One, pursuant to the federal rules, we reserve the right to review and make corrections to the transcript.

Secondly, plaintiff's counsel has brought Dr. Roy Lubit, L-u-b-i-t, with him today. He has represented him as his expert. So there are two things. One, we will object to any other expert being identified insofar as the psychiatric issues, given that Dr. Lubit is here today.

Secondly, in light of Judge Sweet's prior ruling that all objections will be reserved for trial, I am not going to bust this deposition

on the grounds that I believe that Dr. Lubit does not have a right to be here.

However, we reserve our right to take the position at trial that this entire deposition transcript is annuled as a result of Dr. Lubit's presence and that it should not be and cannot be used for any purpose, whether it be impeachment or any other reason at the time of trial.

MR. SMITH: Okay, and of course, the plaintiff disagrees with the assertions by defense counsel that the doctor is not entitled to be here. I also disagree with the assertion that somehow him being here as an agent of a party somehow precludes some other agent for appearing on some other occasion. I know of no law or basis and reason for such a position.

Finally, there is no basis that I can see for reserving some right at an unknown date for some unknown reason to maintain an objection to this

deposition, which is now going forward.

Would you mind swearing in the witness.

V I N O D D H A R, a Witness herein, having been first duly sworn by a Notary Public within and for the State of New York, was examined and testified as follows:

EXAMINATION BY

MR. SMITH:

Q. Will you state your name and address for the record, please.

A. My first name is V-i-n-o-d, V as "Victor" last name is Dhar, D as "David" h-a-r, address is Jamaica Hospital, 8900 Van Wyck Expressway, Jamaica.

MR. SMITH: Counsel, as we've done in the past with some of the other witnesses, I understand the witness has provided his business address. That's fine with me. I don't want to pry into any kind of personal residence issues, but I would only need the residence

information if at the time of trial or some other hearing, I would need to serve process on the doctor.

Given that, would you agree to accept service of any papers that I need to serve on the doctor for him to appear as the 30(b)(6) witness in any future proceedings.

MR. RADOMISLI: If he's still an employee of Jamaica Hospital at the time, we would accept service, but otherwise we would not. If you just want to ask him his address, you might be better off.

Q. All right, would you mind providing us with your address, Doctor?

A. My home address is 60, 6-0 Juniper Lane, Syosset, New York.

Q. Where are you currently working?

A. I work at Jamaica Medical Hospital.

Q. What's your title?

A. I am currently the associate chairman of the department of psychiatry.

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Q. How long have you had that position?

A. I have had that position for five -- almost nine years. Actually at Jamaica Hospital it would be seven years.

Q. Have you had any other positions while working at Jamaica Hospital?

A. Yes. I started as an attending. Then the unit chief, and I went to Flushing Hospital. That's where I got my promotion to associate chairman.

Q. What's the relationship between Flushing Hospital and Jamaica Hospital?

MR. RADOMISLI: Objection to form. You can answer.

A. In 1999 Jamaica Hospital took over Flushing Hospital and came under the umbrella Medisys Network. So it was part of the consortium in the same department.

Q. When did you start working at Jamaica as an attending?

A. That was 1996.

Q. And?

A. To 1999 and then from 1999 to

2007, I was at Flushing.

Q. When you were attending, were you an attending in the psychiatric ward?

A. I was inpatient psychiatric unit.

Q. Is that the same thing as being in a ward?

A. Yeah.

Q. You also mentioned that you were unit chief, what was that?

A. Well, unit chief is responsible for the both administrative and clinical aspects of the inpatient unit, one unit.

Q. What was your title at Flushing Hospital?

A. It started with the unit chief and as we progressed in Flushing, then I became the assistant director of inpatient services and then the associate chairman of the entire department.

Q. Prior to joining Jamaica Hospital in 1999, did you have any other work?

A. Yes. I was in Dayton, Dayton

Mental Health Center from 1990 to 1995, '96.

Q. What did you do in Dayton?

A. I was an attending there.

Q. Where is Dayton?

A. Dayton, Ohio.

Q. What did you do from 1996 -- so '96 you went to Jamaica?

A. Jamaica.

Q. Before Dayton what did you do?

A. I did my training at New York Medical College, Valhalla.

Q. What do you mean by saying you did your training there?

A. I did residency training in psychiatry, general psychiatry.

Q. How long was that?

A. That was three years. Then I did two years of a fellowship in child psychiatry.

Q. Where?

A. Same place, New York -- Westchester Medical Center.

Q. Prior to being at New York Medical College as a resident, what did you

do?

A. I was in India. I came here after I did medical schooling in India.

Q. So you went to medical school in India?

A. Yes.

Q. Which one?

A. It's called Medical College, Government Medical in Kashmir. State of Kashmir.

Q. What were the years of your training at New York Medical College?

A. That would be from 1981 to '86.

Q. And from '86 to 90, what did you do?

A. I worked as an attending at State Hospital, Harlem Valley Psychiatric Center.

Q. Where is that?

A. It's Wingdale, Upstate, New York.

Q. Have you had any other forms of employment, other than at State Hospital, Dayton and Jamaica Hospital?

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A. No.

MR. RADOMISLI: And Flushing.

Q. Right and Flushing. I meant to include Flushing in that since they merged with Jamaica, right?

A. Yes.

Q. So I will just restate that question just to make it clear.

Other than being at State Hospital, Dayton, Flushing and Jamaica Hospital, you had no other employment as a psychiatrist?

A. No.

Q. Have you had any private practice as a psychiatrist?

A. I have -- I am currently in private. It is a part-time small practice, been there since '92 or '93, not sure.

Q. Where is that practice?

A. That's in Forest Hills, Forest Hills.

Q. How much of your working time do you spend at private practice, as opposed to working at Jamaica?

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A. I spend -- I have 40 hours of work at Jamaica and I spend 15 to 20 hours at the most private practice.

Q. So it's about a third of your working time is the private practice; is that fair to say?

A. Yes.

Q. Is it fair to say you have experience making decisions about involuntarily committing patients based on your work experience with State, Dayton, Flushing and Jamaica?

A. Yes. But mainly at Jamaica.

Q. Can you give me an approximation of the number of patients that you've made a decision to involuntarily commit to a psychiatric institution?

MR. RADOMISLI: Objection. This witness is a 30(b)(6) witness and so he could talk about the policy of the hospital. Anything he does personally I am going to object.

MR. SMITH: Are you instructing him not to answer that question?

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MR. RADOMISLI: Yes.

MR. SMITH: It's sort of just getting his background about the issues that he's going to be providing information about. You wouldn't object if I asked if he was a doctor. So I'm not so sure getting some more pedigree information about experience and background is really inappropriate instruction.

MR. RADOMISLI: I think it is.

Q. Well, is it fair to say that you have extensive experience in involuntarily committing patients?

A. Yes. I have experience because I oversee the department.

Q. Did State Hospital have an involuntary policy?

A. Yes, but State Hospital is different and I am not familiar -- I wasn't involved. I was just treating the patients. I don't know how the patients came there or what status.

Q. Well, as an attending at State

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Hospital, did you make decisions to involuntarily commit patients to the psychiatric ward?

MR. RADOMISLI: Same objection.

A. No.

Q. I'm sorry?

MR. RADOMISLI: I said same objection, but he already answered the question.

Q. The answer was no?

A. Objection.

MR. SMITH: Was there an answer?

(Record read.)

MR. CALLAN: Could you read back the question and answer, please.

(Record read.)

Q. As the assistant chair in the department of psychiatric -- the department of psychiatry at Jamaica Hospital, what are your duties?

A. My duties include to see -- to oversee of the day-to-day running of the department, both clinical and administrative.

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Q. What are the day-to-day clinical duties?

A. That means finding out the patients that are in the ER inpatient, any problematic patients, any second opinions on any difficult patients and to attend the administrative meetings.

Q. So is it fair to say that in the clinical part of your responsibilities at Jamaica are to act as a supervisor for the other psychiatrists that are working in the emergency room and in the inpatient ward at Jamaica Hospital?

MR. RADOMISLI: Objection to form and on the grounds that it's a legal conclusion.

A. Yes.

Q. Is the answer yes?

A. Yes.

Q. What did you do to prepare for today's deposition?

A. I don't think I did anything about preparing for the deposition.

Q. Did you review any documents?

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A. I reviewed the regular policies.

Q. Can you describe for me what you're referring to?

A. The hospital policy.

Q. Which one?

A. The CPEP policy, actually.

Q. What's the CPEP policy?

A. CPEP is Comprehensive Psychiatric Emergency Program and the emergency room is part of the CPEP.

Q. Did you review anything else?

A. No.

MR. RADOMISLI: You reviewed other policies, correct?

THE WITNESS: Other policies, yes.

Q. Tell me what policies you reviewed?

A. I reviewed the policy about our emergency admissions and voluntary admissions.

Q. Anything else?

A. Not that I can recall.

Q. Did you speak to anybody, other

than your attorney, about your appearance here today?

A. My department chair knows about that I'm here today.

Q. Who is that?

A. That's Dr. Vivek.

Q. Other than informing your chairman that you were going, did you discuss anything about your testimony with Dr. Vivek?

A. I just informed him that I am going there and he just told me to stay calm and answer what you know.

Q. And did you speak with anybody else about your deposition?

A. No.

Q. Have you ever spoken with a Dr. Isakov about this case?

A. No.

Q. Have you ever spoken with Dr. Bernier about this case?

A. No.

Q. Have you ever spoken with anybody, to your recollection, about Adrian

Schoolcraft?

A. Actually, no, I haven't spoken about this case anytime. No, I wasn't involved with this case, no.

Q. So I take it that you've never looked at the patient's chart in this case?

A. That's correct. I never looked.

Q. And you never had any discussions with anybody about the contents of the chart?

A. No.

Q. That's correct, you never had any discussions with anybody about --

A. I never had any discussion, no.

Q. One of the ground rules of the depositions, I will just cover it now, is it's important that you let me ask my whole long meandering question, so that the court reporter can take it down, give your lawyer a chance to interject and then you get to answer.

A. I'm sorry.

Q. No, it's okay, but if you anticipate which is common, what I am asking

you and you answer it, she has to stop taking down what I'm saying and break the transcript up and say what you're saying, so just take your time.

A. Sure.

Q. We're not in a hurry.

A. One thing that my chairman told me is just relax.

Q. Well, I won't tell him.

A. Okay.

Q. The other really important instruction is that since you're under oath, it's important that you understand the question, so if I ask you a question and you're not sure about what I am asking you, please let me know; okay?

A. Sure.

Q. Let show you what's been marked as Exhibit 30 or Exhibit 130. I have copies for everybody. This is a multipage document containing several Jamaica policy statements that were provided in discovery in this case.

A. Yeah.

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Q. Are you -- I'm going to ask you a lot of questions about these documents, but before we get into each individual policy, you mentioned that you had looked at a CPEP policy. Is that in this collection?

A. No. This is exclusively for the emergency room.

Q. Which is exclusively for the emergency room?

A. This policy.

MR. RADOMISLI: Well, in 2009 did they have the CPEP?

THE WITNESS: No.

MR. SMITH: Okay. So I'm not sure, Greg, that the documents that the witness has testified that he looked at has been produced?

MR. RADOMISLI: I'm sure it hasn't and I didn't know he looked at it frankly, because as we just established, there was no CPEP in 2009.

MR. SMITH: Well, you established it. I didn't establish it.

MR. RADOMISLI: You can --

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MR. SMITH: In any event, I understand and I'm not disputing that fact with you, but just as a matter of form, I would like to know what the witness has reviewed in preparing for the deposition. I am going to make a request for a copy of the CPEP policy.

MR. RADOMISLI: CPEP.

MR. SMITH: Whatever it is. Have it produced.

MR. RADOMISLI: Taken under advisement. Please follow-up in writing.

Q. You don't have a copy of that policy with you, do you?

A. No, I didn't bring it with me, no.

Q. Did you review, in preparing for your deposition any of the policy statements that are contained within Exhibit 130?

A. Well, actually this is part of the CPEP. This is one of the components of the CPEP. It's not going to be different from the policy of the CPEP. The CPEP has

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three components and this is one of the components of the CPEP.

MR. RADOMISLI: Did you review anything, other than the documents that are in front of you today?

THE WITNESS: Yes. A different policy, but that doesn't -- called from CPEP, Comprehensive thing about the program, CPEP.

Q. You see the first page of this document?

A. Yeah.

Q. It's entitled Department of Psychiatry Emergency Room Services. See that?

A. Yeah.

Q. This page, did you review this page in preparing for your deposition?

A. I mean, I didn't look at it for preparing for the deposition, but I have read it. I know about it.

Q. When was the last time you read this page of this exhibit?

A. I wouldn't recall the last time

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I read it.

Q. You see on the bottom there's some notations about review and revise?

A. Hmm-mm.

Q. And then there's some dates?

A. Yes.

Q. Do you see that?

A. Yes.

Q. Do you have any knowledge about what those dates are?

A. Well, when our policy is created every year they're supposed to review and update. So this is what it means, it was reviewed and revised.

Q. Do you know who did the reviewing and the revising?

A. It is generally done by the administrative staff, administrator and the chairman.

Q. And in October and November 2009, who was the administrative staff person involved from in the creation of this policy?

MR. LEE: Objection to the form.

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A. I don't know. He is not there now. I think his name was Mr. Mule.

Q. Can you spell that for me?

A. M-u-l-e.

Q. Who was the chair?

A. No, he -- the chair was Vivek, Dr. Vivek.

Q. Did you personally have any roll in the review and revising of department of psychiatric, psychiatry admission procedures?

A. Yes, review.

Q. Were you part of a committee that would regularly review this or was it on an ad hoc basis that you would review the procedure?

A. On ad hoc basis.

Q. See the second page of this exhibit?

A. Yes.

Q. There is another policy statement called involuntary legal status?

A. Yeah.

Q. Can you tell me what that

statement is about?

A. Can I review it for a second?

Q. Yeah, sure.

A. This is 927. That means any involuntary patient -- a patient who needs to be admitted to the hospital, psychiatric hospital on an involuntary basis can be admitted by what's called a two physician certification.

Q. And that's what this policy provides for?

A. Yes.

Q. How many ways can a patient be involuntary committed to the psychiatric emergency room or the psychiatric ward at Jamaica Hospital?

MR. RADOMISLI: Objection to the form.

A. There are essentially only one way -- two ways. One is 939, and under that article you can admit a patient who is potentially dangerous to self or others to a psychiatric emergency room.

Q. What's the other way?

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A. Other way is the patient can be admitted on 2PC.

Q. And that's this 927?

A. 927, yeah.

Q. How is 939 and 927, how are they different?

A. 939 is when a patient comes directly into the emergency room and he is brought by -- there is a number of agencies that can bring the patient there. 927 is when a patient is transferred from other hospital on an involuntary basis.

Q. Is 939 what's known as an emergency involuntary commitment?

A. Yes.

MR. RADOMISLI: Objection to form.

Q. What are the types of agencies that bring in an individual under 939?

A. I think there is a police officer, director of community services, physicians, psychiatrists, and family member can apply or someone who is interested can apply for patient put in application for

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patient involuntary admission and through the court system.

MR. RADOMISLI: He asked you about 939 only.

THE WITNESS: Yeah.

Q. In order for a patient to be involuntary committed under 939, what medical or psychiatric conclusions need to be made?

MR. RADOMISLI: I've given you a little bit leeway, but you're going beyond the scope. If you're just asking in general, you want to say pursuant to the Jamaica Hospital policy.

MR. SMITH: Okay. All right, that's fine. I will restate the question.

MR. RADOMISLI: Then he can look at the policy if you want.

MR. SMITH: Well -- I don't want him to just read back what the words on the paper are. I want to know how the policy is actually applied and

effectuated. If it was just to read the piece of paper we wouldn't need a witness. I could just read it in my office.

MR. RADOMISLI: No. No. I understand that. You can go through the policy and ask him what it all means. That's fine, but it's just the general.

MR. SMITH: All right, okay. So then I will rephrase the question the way your counsel has requested that I do so.

Q. Under Jamaica Hospital's policy, what medical or psychiatric conclusions are required in order to involuntarily commit a patient to the hospital, either in the psychiatric emergency room or in an inpatient service area or a ward?

MR. RADOMISLI: Under 939?

MR. SMITH: Under 939.

A. Patient has to be --

MR. SMITH: The record should reflect that counsel has just shown the

witness the emergency admission policy of the hospital.

MR. RADOMISLI: Which is part of Exhibit 130.

MR. SMITH: Right, I know, but it's slightly suggestive of you to be showing him documents when I'm asking him questions.

MR. RADOMISLI: I don't think it's suggestive.

MR. LEE: Wasn't the question about the policy?

MR. SMITH: You too now want to join in on this?

Q. Can you just answer my question, please?

A. A patient has to be a danger to self or someone else. That dangerousness or patient has to be not capable of taking care of himself for medical or his health or his living arrangement.

Q. And how do the staff at the hospital make this determination about dangerousness?

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A. It's based on what the -- when the patient comes to the hospital, the report, accompanying person. And then it is evaluation by the psychiatrist.

Q. Is there any methodology or a checklist or some other factors that are regularly looked at in effectuating the Jamaica Hospital policy?

A. Yeah. I mean, there is about policy regarding psychiatric evaluation, how that is to be done, what is to be noted in that evaluation, and based on that evaluation you're to come up to a diagnosis and then based on the diagnosis, you then make a decision.

Q. Are some of the factors that you just identified -- let me rephrase that question.

The factors that you just identified for the psychiatric evaluation, are those factors that are examined for purposes of determining whether or not a person has a mental illness or are they looked at for purposes of determining

whether or not that person is a danger to themselves or to others or is it just a combination of things?

A. Combination.

Q. So can you tell me what are the factors under the Jamaica Hospital policy that are looked at in order to determine whether or not a patient is dangerous to himself or herself or others?

A. Patients -- when patients are brought in by any agency, and based on their reports and what are the reasons why the patient was coming in, brought to the hospital and that would be the sort of the starting point.

Q. So that's the beginning of the information that's required to find out what the relator or the provider of the information says, right?

A. Yes.

Q. Can you tell me what other factors are looked at in making this assessment?

A. Well, there is you do the

comprehensive psychiatric evaluation to see whether the patient has any history of mental illness. On dangerousness you have to see what are the circumstances under which the patient was brought to the hospital and were there any specific threats made or what was mentioned.

Q. I'm sorry, any specific what?

A. Threats.

Q. Anything else?

A. Well, we're also going to the background, history, if we have any information resources at that time to get the person's history.

Q. Are there any standard guides that are employed or used by Jamaica Hospital in making this assessment of dangerousness?

MR. RADOMISLI: Can you read that back.

(Record read.)

A. Yes.

MR. RADOMISLI: Just a second.

MR. LEE: Can we agree that all

of your questions are as these policies existed in 2009, not as they currently exist since? The question was of a present tense question?

MR. SMITH: Was. They've all been like that.

MR. LEE: Obviously, what was the standard, if any, applied in 2009.

MR. SMITH: Well, once I figure out what the standard is, then I can ask.

MR. LEE: It may be different now.

MR. SMITH: Yeah, no, I know.

MR. RADOMISLI: Well, I've been interpreting it as 2009.

Q. Can you just answer my question?

MR. SMITH: I think your suggestion is a good one, Brian, so I will try and get to the bottom of the issue right now.

Q. Can you answer my question?

A. Can you repeat the question?

(Record read.)

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MR. RADOMISLI: As part of the policy in 2009.

MR. SMITH: Yes, okay fine.

MR. RADOMISLI: Objection to form.

A. We have the policy in place now --

MR. RADOMISLI: Not now. 2009.

A. 2009 I'm not sure. I'm -- I don't recall of any checklist or any other way of examining, other than based on the history.

Q. The history is this comprehensive psychiatric evaluation?

A. Yes.

Q. How long does that typically last?

A. It lasts -- it can last anytime anywhere from an hour or you may have to redo the evaluation from time to time.

Q. So it can take an hour or more?

A. Yes.

Q. What is or what are the guidelines or the factors that Jamaica

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Hospital looks at today in making this dangerousness assessment?

MR. RADOMISLI: I'm going to object and direct the witness not to answer.

MR. SMITH: Well, the only way for me to get this is to find out whether or not if he doesn't have a specific recollection of what the status was of a policy in 2009 I need to be able to find out what he knows about what the policy is today which he clearly is capable of providing me and then find out whether or not he has any reason to think that it's changed since 2009.

MR. RADOMISLI: Well, how could he know if it's changed or not if he doesn't recall what the policy is in 2009?

MR. SMITH: Well, the question as formed it's impossible, nobody has a photograph memory about what was going on in a particular place when you got a

moving entity. So it's just -- if you want to interfere with the examination in this way, then you can go ahead and do so and we will just have to bring the doctor back.

MR. RADOMISLI: I don't want to interfere. I want to assert a legitimate objection and I believe him to testify about the policy today when the treatment was in 2009 is a legitimate basis for me to object and direct him not to answer the question.

MR. SMITH: Well, it's not a proper basis for direction not to answer the question. Since the judge is away on vacation, you're just taking advantage of that fact and we are just going to have the witness come back and come back to my office and I will make the application if you're going to stand by that instruction.

MR. RADOMISLI: How is what the policy is today relevant to what's pertinent in 2009?

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MR. SMITH: I want to be able to find out what the policy is today, so I could find out whether or not he has knowledge about whether or not it's changed in the last five years.

MR. RADOMISLI: Okay. So why don't you ask him if he knows whether or not it's changed before --

MR. SMITH: First, I need to establish what it is. This is really getting absurd. This is getting absurd. You want to play games with me --

MR. RADOMISLI: No, I don't want to play --

MR. SMITH: Then we'll just cut it out and I will just make the application now.

MR. RADOMISLI: I don't want to play games at all. I want to be able to --

MR. SMITH: Well, you're playing games --

MR. RADOMISLI: -- I don't --

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MR. SMITH: The witness can't tell me what the actual policy was five years ago, but the witness can certainly tell me generally what the policy has been over the past few years and whether or not it's changed. Okay.

MR. RADOMISLI: Ask him if he knows whether or not it's changed. Regardless what the policy is, you can ask him do you know --

Q. To your knowledge, sir, since you joined or started working at Jamaica Hospital, has its policy about assessing the dangerousness of a patient changed?

A. My knowledge it has.

Q. How has it changed?

MR. LEE: Just note my objection.

MR. SMITH: Great.

MR. RADOMISLI: Between 2007 and 2009?

MR. SMITH: No.

Q. How has it changed in the history of your career at Jamaica, how has

the assessment of the dangerousness changed?

MR. RADOMISLI: I dont' believe he's permitted to answer or required to answer questions about things that occurred after 2009, including the policy.

MR. SMITH: So you're going to direct him not to answer the question.

MR. RADOMISLI: In that form. If you want to limit to anything that occurred while he was there --

MR. SMITH: You just told me because your co-counsel suggested it to him that he doesn't have any recollection about what the policy was in 2009, okay. So now I've asked the question broadly and you're objecting to that. So if you want to continue to interfere with my examination I'm going to stop and I'll call the judge and I will tell him what's going on and we will decide and we'll be here all day long with this nonsense.

MR. RADOMISLI: If you want to

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call the judge and get a ruling now, that's fine with me.

MR. LEE: Let me just say I didn't suggest anything, other than --

MR. SMITH: Yes, you did. You did. You started this problem, Brian.

MR. LEE: This is what the deposition is about. It's about the policy --

MR. SMITH: It's about you getting in the way of my finding out basic information policy. That's what it's about.

MR. LEE: I respectfully disagree with that.

MR. RADOMISLI: If you're going to call the court, please do in our presence.

MR. SMITH: We are going off the record.

(Discussion off the record.)

MR. SMITH: Going back on the record. It's 11:21.

While we were off the record for

about looks like 20, 25 minutes I called the court at 10:54, I spoke with Judge Sweet's law clerk, Adam Chen. We had a -- I think it was an on the record discussion or an off the record discussion about instructions not to answer certain questions and Mr. Chen said that since Judge Sweet is away, he didn't know whether or not he was going to be able to get back to us with a ruling and we've waited or I've waited approximately 25 minutes and there has been no indication from the court that we will get a ruling. So I am going to proceed with my examination and note that I object to the needless interference with the order and methodology with which I wanted to take this witness' deposition.

Q. Can you turn, sir, to Exhibit 130. You have that still in front of you?

A. Yeah.

Q. Do you have an emergency

admission status policy, which is the fourth, fifth and the sixth page of the exhibit?

A. The page number?

Q. It's page number -- start on page 17 and it goes through 19.

A. Okay.

Q. Yes.

MR. RADOMISLI: Starting at 17.

Q. Starting with 17, please.

A. Okay, sure.

Q. Are you familiar with this policy statement?

A. Yes, I'm familiar.

Q. When was the last time, other than just now, that you've read this statement?

A. This I read recently when I reviewed the policy on CPEP.

Q. So this was one of the policy statements that was part of the statements that you reviewed?

A. CPEP.

Q. Did you have any role in the

creation of this document, this three-page document, which is pages 17, 18 and 19?

A. No.

Q. Who created this document?

A. This is created by the administration -- administrator and the chairman.

Q. Who are those people?

A. Same people, Mr. Mule and Dr. Vivek.

Q. The administrator. Is this what we refer to as the 939 admission or involuntary admission?

A. That's correct.

Q. In the second paragraph under heading policy it says that the patient's alleged to have a mental illness. Do you see that reference there to a mental illness?

A. Yeah.

Q. Am I correct that one of things that's required in order to admit somebody involuntary is a medical or psychiatric determination that an individual has a

mental illness?

MR. RADOMISLI: Objection.

MR. CALLAN: Object to the form of the question.

Q. Is that correct? You could answer.

A. Yes.

Q. And am I correct that the comprehensive psychiatric evaluation is the means whereby a determination of this mental illness issue is made?

A. Yes.

Q. You said the comprehensive psychiatric evaluation, it takes an hour or more? Right, remember saying that?

A. Yes.

MR. CALLAN: Objection to the form. Are you talking about -- I just want to know the timeframe you're talking about. Are you talking about currently or in general or --

MR. SMITH: I'm talking about in general.

MR. CALLAN: This is in general?

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MR. SMITH: Yes, this is in general.

MR. CALLAN: I object to the form of the question and I also object on the grounds that it's not relevant as to what the current policy is.

MR. LEE: I join.

MR. RADOMISLI: Me too.

Q. You said that the comprehensive psychiatric evaluation takes an hour or more, right?

A. Yes.

Q. Is the hour or more, is that the assessment that's done by the professional of the patient?

A. By the psychiatrist.

Q. So the psychiatrist spends at least an hour with the patient; is that correct?

A. Yes.

Q. Does the psychiatrist spend time speaking with anybody else?

A. The psychiatrist has to spend time with the person who brings the patient

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in, the staff that saw the patient, the family members or any other source of information that he can get information from.

Q. Does the hospital policy provide for the training for staff to conduct this kind of assessment?

A. Yes.

Q. How?

A. Well, if you're a -- you've done a residency in psychiatry that makes you -- that qualifies you to do a psychiatric examination. Then there are from time to time in-services and updates in the psychiatry examination.

Q. How long does it take the resident to become qualified to do this evaluation?

MR. RADOMISLI: I am going to object. It's beyond the scope. Don't answer.

MR. SMITH: Don't answer the question?

MR. RADOMISLI: It's beyond the

scope of the deposition.

MR. SMITH: So that's a relevancy objection.

MR. RADOMISLI: There is a court order limiting this examination to the policy and procedure at Jamaica Hospital regarding involuntary hospitalization. That question does not go to it.

MR. SMITH: It doesn't? What does it go --

MR. RADOMISLI: Training.

MR. SMITH: It goes to how the policy is effectuated at the hospital. So I mean like I said before --

MR. RADOMISLI: It doesn't.

MR. SMITH: So how the hospital or whether or not the hospital provides any means for its personnel to figure out whether or not somebody has a mental illness isn't relevant to the policy of hospital?

MR. RADOMISLI: I thought you already asked that question.

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MR. SMITH: I'm trying to find out what the hospital does to find out whether or not the people who are making this assessment about mental illness have any qualifications to do so. You don't think that goes to their policy? Or maybe their policy is to have people who have no medical training at all to make these assessments. You want to tell me whether or not that's an appropriate question?

Q. Doctor tell me this, do the people who make the assessments under Jamaica Hospital policy have any training or any qualifications for making the decisions they make?

MR. RADOMISLI: Asked and answered.

Q. You can answer it again. Do they have any training, do they have any experience, what experience do they have if they have any?

MR. CALLAN: Objection.

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MR. LEE: Objection.

MR. RADOMISLI: Objection. That's beyond the scope and to the form.

MR. SMITH: You're telling him not to answer that question?

MR. RADOMISLI: It's an improper question based on the court order limiting this deposition.

MR. SMITH: This is beyond the -- you are doing whatever you can to interfere with my ability to ask basic questions --

MR. RADOMISLI: I am just asking you to comply with the court --

MR. SMITH: No, you're not. This is ridiculous. I can read the policy statement. What you're basically telling me is if I don't ask you what it says in black and white on the page he doesn't have to answer the question. I don't know how you're interpreting this court order and you haven't explained to me how.

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MR. RADOMISLI: I'll tell you. You could do what you did before, which is ask him to explain all the terms which are on the policy.

MR. SMITH: All right, well, the witness is going to have to come back and I'm not going to do this at your office any more.

MR. RADOMISLI: Do you think things would be going differently if we were at your office?

MR. SMITH: No, I am just not going to accomodate you in the way that you've requested that I accomodate you in the past, because I've come up here, brought my assistants and --

MR. RADOMISLI: Entourage --

MR. SMITH: -- And my files with me and this is what I get. So the cooperation that I've extended to you in the past is not going to come -- the witness will have to come and come back to my office.

MR. RADOMISLI: We will see.

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MR. SMITH: Right. We will see.

Q. So how does Jamaica make sure that its policy about determining about whether or not somebody has a mental illness is complied with?

A. By psychiatric evaluation.

Q. How does Jamaica determine that the people doing the evaluation have any qualifications to do that?

MR. RADOMISLI: Objection. Beyond the scope.

Q. You want to answer my question?

MR. RADOMISLI: No. I'm objecting. I'm directing him not to answer. It's beyond the scope of the deposition given the court order.

Q. What is the mental illness within the meaning of this policy statement?

A. Mental illness is any sort of illness that meets the criteria of the DSM-IV.

Q. What are those?

A. Well, there are different kinds of mental illnesses.

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Q. Tell me all of them.

MR. RADOMISLI: All of them?

Q. Yeah, I want to know what the mental illnesses that fall within the scope of this policy scope are?

MR. RADOMISLI: If -- you can't ask him to go through and recite the DSM-IV, but you can certainly --

MR. SMITH: Excuse me, your function here is to object. If you want to interfere, you can tell him not to answer that question, but your speeches are inappropriate. Okay. So cut it out. I'm done with the interference. Completely done. You can instruct him not to answer the question. You can object to the form or you can leave. Those are your choices. Which is it going to be?

MR. RADOMISLI: Well, I'm not going to limit myself to those options. But for this particular question, I will object to the form.

Q. You want to answer the question,

please? What are the mental illnesses that fall within the scope of this term that fall within this term that's in your policy statement?

MR. RADOMISLI: Objection to the form.

THE WITNESS: I can answer?

MR. RADOMISLI: Yes.

A. Okay. Mental illness is any person, who because of mental illness, mental illness means a number of diseases, number of problems. It could be from schizophrenia, psychosis to depression, to traumatic brain injury and that results in symptoms causing harm to self or others.

Q. Any other conditions that fall within the definition of mental illness within the policy statement?

MR. RADOMISLI: Objection to form, asked and answered. You can answer.

A. There are a number of diseases under the DSM-IV, but this criteria is specific for any condition that could lead

to a person being harmed self and others. It could be from panic attack, it could be from acute anxiety, it could be from brief psychotic episode. So there are a number illnesses which don't necessarily meet this criteria.

Q. Can you explain that answer? I don't understand that.

A. The patient is suffering from -- let me rephrase it. Patient comes with a behavior, certain behavior, we have to determine whether that patient -- whether the behavior is because of mental illness. We have to do an examination to figure out what kind of mental illness this patient is suffering from. But before we come to that, we have to keep the patient in the emergency room to figure out what's going on.

Q. In the second paragraph of this policy statement there is a phrase that reads: Patient's alleged to have a mental illness for which immediate observation, care and treatment in the hospital is appropriate. That's the first part of that

policy statement. You see that?

A. Yes.

Q. Do I understand you to be telling me that any kind of mental illness can qualify for the type of mental illness which can lead to an involuntary commitment to the patient?

MR. RADOMISLI: Objection. Scope.

A. What I am saying is that patient alleged to have mental illness for immediate observation, care and treatment in the hospital is appropriate can qualify for that.

Q. What I want to know, what are the kinds of mental illnesses that are being referred to in this policy statement?

MR. RADOMISLI: Asked and answered.

A. Same I mentioned before, any kind of illness, any kind of behavior can qualify for this statement.

Q. So any mental illness; is that fair to say?

A. Yes.

Q. And it says in the statement here it's a mental illness for which immediate observation, care and treatment is appropriate?

A. Yes.

Q. Why does it have to be for immediate observation, care and treatment?

A. Because of the dangerousness.

Q. When a patient is brought into Jamaica Hospital and is being assessed under this policy statement, does the comprehensive psychiatric evaluation have to be done right away?

A. Not necessarily. It can be done in an unspecified time. Immediately you have to see whether there is any acute symptoms that need to be controlled. If the patient is not cooperative, you cannot do it, you cannot examine the patient, the patient is not willing to be examined -- answer questions. So it has to be -- it's very -- it's actuality not specified what exactly means immediate evaluation. It

could be as soon as the patient comes in you can start the treatment or it could be until the patient is willing to talk.

Q. Does Jamaica Hospital have a policy about when the comprehensive psychiatric evaluation has to be conducted by?

A. There is not a policy, but it's standard that within eight hours admission to the emergency room and it also depends on how busy the ER is.

Q. Do I understand what you're saying that there's no written policy at Jamaica Hospital for when the psychiatric evaluation has to be conducted by?

A. Not that I'm familiar with.

Q. But you're telling me there is a practice of doing so?

A. It's eight hours.

Q. And that's not in writing?

A. That's not in writing.

Q. And it's eight hours depending upon -- you also said it's eight hours, it was also depending upon how busy the ER was?

A. How busy the eye ER was.

Q. When you're referring to the ER, you're referring to the medical ER or the --

A. No, referring to the psychiatric.

Q. So we're talking about the psychiatric ER; is that correct?

A. Yes.

Q. How is this eight hour practice communicated to the staff that are expected to comply with it?

A. It's done through in-services.

Q. I don't understand what that means.

A. It means when you have staff meetings, you talk about how -- within what timeframe the assessment should be done and how if there's a problem or anything whether you need a second staff member. That's how it is taught to the staff.

Q. So the eight-hour goal or practice objective is discussed at staff meetings; is that correct?

MR. RADOMISLI: Objection to the

form. You can answer.

A. Yes, it's a in-service. It is our case conferences, in-services and staff meetings.

Q. This practice of the hospital of having this comprehensive psychiatric evaluation done within eight hours, depending upon how busy the psych ER, that evaluation has to be done by who under the --

A. The staff psychiatrist who has been given by the privileges in the hospital by credential committee and approved by the chairman.

Q. Who were the staff psychiatrists in 2009 that were the ones that were required to conduct this comprehensive evaluation?

MR. RADOMISLI: Objection to form and the scope.

MR. CALLAN: Join in the objection.

MR. LEE: Objection.

MR. RADOMISLI: But you can

answer.

A. The are a number of psychiatrists who work in the emergency room. Some who are called on-call, meaning they provide extra services during evening and night hours, but the main person during the daytime was Dr. Bernier.

Q. Other than these on-call psychiatrists and Dr. Bernier, was there anybody else who could do the comprehensive psychiatric evaluation in October or November 2009?

MR. RADOMISLI: Objection to form and scope.

A. I am not sure if we had residents at that time, but if they're residents, they could do it, resident physician, under the supervision of the attending psychiatrist.

Q. When you say a resident, what do you mean?

A. Resident is a physician who is undergoing postgraduate training in psychiatry.

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Q. Is there any requirement that the resident have a certain level of experience before they do a comprehensive psychiatric evaluation?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to the form and beyond the scope.

A. They have to be observed for period of three months, six months and once they -- the attending says that they're qualified to -- that they can independently make an assessment, regardless of whether they make independent assessment or not, it still has to be done under the supervision of the psychiatrist.

Q. What is this threshold three to six month period called at Jamaica Hospital?

A. It's not actually Jamaica Hospital policy. It's what's known as residency program policy. That a resident will not be allowed to see patients independently until the attending psychiatrist supervising him or her is confident that the resident can be

independent evaluation.

Q. What is this threshold called at Jamaica Hospital?

A. I'm not aware of any specific name.

Q. Does Jamaica Hospital have any requirements in it's policies for documenting when a resident meets this threshold so that they are considered qualified to conduct a comprehensive psychiatric evaluation?

A. Not that I'm aware of.

Q. So it's not the kind of thing that gets put in the personnel file of the resident?

A. No.

Q. Going back to the policy statement on the emergency admission status subject line. It also says that there is a reference here that patient alleged to have mental illness and which is likely to result in the serious harm to himself and others. You see that?

A. Yes.

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Q. What is that policy statement based on?

A. That's based on the New York State Mental Hygiene Law Article 9.

Q. Did a lawyer assist Jamaica Hospital in crafting this policy statement?

A. I'm not aware of it.

Q. I am sorry?

A. I'm not aware.

Q. Have you ever read the New York Law on the Section 9.39?

A. Yes, I have to. Yes.

Q. Does Jamaica Hospital's policy endeavor to comply with Section 9.39 of the Mental Hygiene Law?

MR. RADOMISLI: As it existed in 2009?

MR. SMITH: Yes.

A. Yes.

Q. Has the mental Hygiene Law Section 9.39 changed since 2009?

MR. RADOMISLI: Don't answer the question.

Q. Do you know whether or not

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Section 9.39 of the Mental Hygiene Law has changed since 2009?

MR. RADOMISLI: Read that back.

(Record read.)

MR. RADOMISLI: I am going to object. He's not a lawyer.

MR. SMITH: I am not asking for a legal opinion. I want to know whether or not he knows if the statute changed. I have a copy of it. You want me to show it to him. It hasn't changed.

MR. RADOMISLI: Are you representing that it hasn't changed?

MR. SMITH: Here's a copy of the statute obtained from Lexis. The alleged date of history shows it was created in '77 and it was amended most recently in 1986.

MR. RADOMISLI: Okay.

MR. SMITH: I would still like to know whether or not he thinks it's changed 'cause there's so much at stake here about moving target of the Jamaica

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Hospital over the past 15 years.

MR. RADOMISLI: Well, but you've already represented that it hasn't and you have the policy in front of you.

MR. SMITH: I know what the law is, but he's the witness. If he thinks that the policy had changed or the law has changed, which was the basis for the policy, then he can tell me, but I suspect that if you let him answer the question he's going to say I don't know if it's ever changed, it's been the same ever since I have been at Jamaica Hospital in 1996. But maybe he will say something else. I don't know.

MR. RADOMISLI: Do you know whether it has changed?

A. I'm not aware of any change, no.

Q. Would you like to see a copy of the law?

MR. RADOMISLI: Well --

Q. You said you read it before?

A. Yeah.

MR. SMITH: All right, so let's

mark it. Let's show it to the witness.

(Plaintiff's Exhibit 151, document, was marked for identification as of this date.)

Q. Have you had the chance to look at 9.39?

A. Yes.

Q. And you've said you read it before?

A. I have gone over it.

Q. And you're not aware of any changes in this statute, are you?

A. I'm not aware, no.

Q. It says at the bottom of the first page, it says the director shall admit such person. You see that, sir?

A. Hmm-mm.

Q. You have to say or no. Just yes or know. Uh-huh comes out --

A. Yes.

Q. Okay. It says only if a staff physician of the hospital. So that's a staff physician that you're referring to earlier, right?

A. That's the attending psychiatrist.

Q. Attending psychiatrist. Okay.

A. Yes.

Q. It says that the director under the statute shall admit the person. Does Jamaica have a director or somebody who makes this decision or is that basically the staff physician or attending who makes that decision?

A. It's the attending who makes the decision.

Q. So is there a director of the hospital who is required to make the final decision on admitting a patient pursuant to Section 9.39?

A. No. There is no director or any other person who is required to approve or -- but it is done on the -- because director -- it's staff psychiatrist in the hospital -- in the emergency room is the one who makes the decision.

Q. Is there anybody who holds the title of director at the hospital or is it

really chairman?

A. Well, it's actually, there is a medical director in the ER, psych ER.

Q. Who is that?

A. Dr. Bernier was the medical director at that time.

Q. What's the role of a medical director, other than making these final sign-off decisions on involuntaries?

A. Basically overseeing, reviewing all the cases and supervising residents and nurses and other physicians.

Q. All right, and then going back to the policy statement, page 17, Exhibit 130 at the bottom of that page it says the admitting physician must be licensed in New York State. You see that?

A. Yes.

Q. All right. Is the admitting physician within this policy the same as the attending physician and the staff physician as we have been discussing, is that all the same person?

MR. RADOMISLI: Objection to

form.

A. Admitting physician would be same, yes.

Q. So the admitting physician is the same as the staff physician, right?

A. Well --

MR. RADOMISLI: Objection to form.

A. -- it could be the staff physician or it could be the director, any of the physicians.

Q. On the same page there is a phrase likely to result in serious harm. Do you see that?

A. Hmm-mm.

Q. You have to say yes.

A. Yes. I'm sorry.

Q. And then the policy defines likelihood to result in serious harm in two ways, numbered one and two. You see that?

A. Yeah.

Q. And am I correct that the first definition deals with categories of dangerousness to oneself and the second

category deals with dangerousness to others?

A. Yes.

Q. You see the phrase manifested by?

A. Yes.

Q. What does that mean?

A. It could be any kind of behavior that is out of control or violent behavior or threats to some other people.

Q. Am I correct that manifested by requires that the patient either engage in some conduct or makes some sort of statement that suggests that the person is dangerous to themselves?

A. Yes.

Q. It also goes on to say "Or other conduct demonstrating that he is dangerous to himself." You see that?

A. Yes. Can you specify where?

Q. In sub one --

A. Yeah.

Q. -- in the definition of likelihood to result in serious harm there is a phrase or other conduct demonstrating

that he is dangerous to himself. You see that?

A. Yes.

Q. What kind of conduct under the Jamaica policy is the kind of conduct that demonstrates that a person is a danger to himself or herself?

A. Any kind of behavior that a person puts himself into any physical harm, not able to provide for himself food, clothing, shelter or medical treatment.

Q. Is there any other conduct, other than what you've just said, that is the kind of conduct that demonstrates a person that's a danger to themselves or --

A. I am not aware of anything.

Q. Does the conduct under this policy have to be conduct that the admitting or the staff physician observes?

A. No. It's based on the report that we get from the person who brings the patient in.

Q. Is there any policy at Jamaica about determining the reliability of the

reported information?

A. Well, there is no policy, but in general, we, as the staff psychiatrist or director, will try to get information from other sources, but people who come to us generally is reliable.

Q. Why do you say that people who come to you are generally reliable?

A. The people who bring the patients in.

Q. No, I understand that's what you're saying, but I'm saying why do you say that they're generally reliable?

A. Well, because we are -- we take patients from police or from agency, they bring the patient in there or family members.

Q. So is it the policy of Jamaica Hospital to accept without question the information that's provided by the police or family members or some other provider or relator of information?

MR. RADOMISLI: Objection to the form, asked and answered. You can

answer.

A. Yes. Until we find any other resource that we have collateral information. Until then we are obligated to keep that information as valid information.

Q. You say that you're obligated to keep that information as valid information, what is that information based on?

A. It's based on New York State 9.39. That 9.39 emergency room under the order of the commissioner we can receive and retain a person until all the evaluations are done.

Q. No, I understand that 9.39 gives Jamaica Hospital the ability to involuntary commit somebody, but what I am trying to find out is what's the basis for you saying that you're obligated to accept as valid the information that's provided to you by the people who are relating the information to you?

MR. RADOMISLI: Objection to form. You can answer.

A. Until we get the other

information from collateral.

Q. So if a family member comes into Jamaica Hospital and relates information about somebody it's Jamaica's practice or policy to accept that information as true without any assessments or attempt to independently verify it?

A. Yes.

MR. RADOMISLI: Objection.

MR. LEE: Objection.

MR. RADOMISLI: And to form.

Q. The next page of the policy statement has under the headings procedure number of categories, you see that?

A. Yes.

Q. Number one, there's a reference here to following examination and interviews other informants, which may be available should the examining physician consider the patient to meet the criteria above, he should certify his finding on form OMH 474. Do you see that?

A. Yes.

Q. There's a reference here to the

examining physician. You see that?

A. Yes.

Q. Is the examining physician the same person as the staff physician or attending physician?

A. Yes.

Q. That's the same person who conducted the comprehensive psychiatric evaluation, right?

MR. RADOMISLI: Objection to form.

A. Yes.

Q. And the form, what is this form OMH 474?

A. It's a form that when a psychiatrist, attending psychiatrist in his or clinical opinion finds that the patient can be admitted on an involuntary basis and there's a form there, you have to fill that form with the justification why you think the patient should be admitted and based on information and whatever the collateral information, what other sources of information, that's form 474.

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Q. And the staff physician or the attending physician, the one who has conducted the comprehensive psychiatric evaluation, they fill out the form if they make the decision that the person should be involuntarily committed; is that correct?

A. Yes.

Q. Are they required, under Jamaica policy, to fill out that form at any particular time in relation to when they make their decision?

A. As soon as the decision is made, the patient needs to be admitted.

Q. So the policy at Jamaica is to have the form executed as soon as the decision by the psychiatrist is made; is that correct?

A. Yes.

Q. In the next paragraph there is a reference to a number two. Do you see that?

A. Number two?

Q. Yes.

A. Yeah.

Q. It says here the admitting

doctor will record on the form the names of the people. You see that?

A. Yes.

Q. And that's the admitting doctor is the same as the examining doctor?

A. As the examining doctor, yes.

Q. I want to the show what's been previously marked as Exhibit 131. This came from the chart or the file from this particular patient, Schoolcraft was his name.

A. Okay.

Q. I am not going to ask about that, but I am going to ask you about the form itself; okay? All right?

A. Okay.

Q. So can you tell me what this document is?

A. This is a document known as notice of status and rights to the emergency admission. This information is given to the patient. Copy of this information is given to the patient explaining his rights and what the protocol is going to be.

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Q. And is this document also supposed to be given to the patient at the same time as the 474 form is the filled out by the staff physician?

A. Yes.

Q. And so is it policy at Jamaica Hospital for the staff physician, if they make a decision to involuntary commit, to sign page 1 of the 747 and then hand the patient this form notice of status and rights?

A. Yes.

Q. And in this notice it says here, in the form, in the printed form -- by the way, this is a printed form that's created by Jamaica Hospital or by?

A. Department of the Office Mental Health, New York State.

Q. So Jamaica Hospital just gets the form from the Department of Mental Health?

A. Yes.

Q. So this form here says based upon -- "base upon an examination by a staff

physician you have been admitted as an emergency status patient to this hospital for persons with mental illness for immediate observation, care and treatment. Within 48 hours of the time of your admission, you will examined by another physician, who is a member of the psychiatric staff of this hospital." You see that, sir?

A. Yes.

Q. Now, the phrase within 48 hours of the time of your admission. You see that?

A. Yes.

Q. Under Jamaica's policies, when does this 48-hour time period begin?

A. It starts from the time this form is filled -- the 747, the form is signed, that is the time given for that.

Q. Am I correct that the hospital policy and practice is that the comprehensive psychiatric evaluation is done subject to the busyness of the emergency room within eight hours; is that correct?

A. Yes.

Q. And then the evaluation should be conducted within that eight-hour period, correct?

A. Yes.

Q. Then after that comprehensive psychiatric evaluation is done, then the form for 747 is filled out and this notice of rights is provided to the patient at that time; is that correct?

A. Yes.

MR. LEE: Objection to the form.

Q. And then is it the Jamaica Hospital policy that within 48 hours of the signing of the 474 form that a member of psychiatric staff of the hospital has to then do an evaluation of the patient?

A. Yes.

Q. Why is the second evaluation of the patient by a member of the psychiatric staff required?

MR. RADOMISLI: Objection to form. Go ahead.

A. It's a process of checks and

balances and make sure that admission was done properly and that the patient met criteria for admission.

Q. If the initial or staff physician gives a diagnosis and the psychiatric staff member's diagnosis disagrees with the initial assessment, is it the Jamaica Hospital policy to then discharge the patient?

MR. RADOMISLI: Read that back, please.

(Record read.)

MR. LEE: Note my objection to the form.

MR. RADOMISLI: Objecting to the form and also, beyond the scope of the deposition, which deals within involuntary admission.

MR. SMITH: That's what the subject matter of the question is.

MR. RADOMISLI: Subject of the matter of the question is discharging. It's different. Can you rephrase the question?

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MR. SMITH: Are you instructing him not to answer the question?

MR. RADOMISLI: It's beyond the scope.

MR. SMITH: I'm not sure I understand.

MR. RADOMISLI: It's a little nit picky.

MR. SMITH: Yeah, to me it seems very nit picky.

MR. RADOMISLI: But I'll -- just read it back one more time.

(Record read.)

MR. LEE: Note my objection to the form for the record.

MR. RADOMISLI: Can you rephrase the question in such a way that it squarely fits within the scope of this deposition?

MR. SMITH: No, I can't. This is -- this is the -- you're mincing words here. Do you want to split hairs? Then you can split hairs all you want.

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MR. RADOMISLI: Then I will because I am just going by what the court order says and what you asked for and what you asked for was a witness to testify about the policy on involuntary admissions.

MR. SMITH: Right, okay, and so you're telling me that the only time that's relevant to make an inquiry about the hospital's policy is the moment that the staff physician signs the piece of paper saying that yes, we are going keep this person against their will and that anything that happens thereafter is completely irrelevant to the scope of this examination? If you're saying that, which is what I think you're saying then you're taking an extremely narrow view of the court order and needlessly interfering with my deposition.

MR. RADOMISLI: That isn't what I'm saying. Number two, it's not an exceedingly narrow interpretation of

the court order, because when you applied to -- when you served the 30(b)(6) and when -- subject to the motion, you only asked about policies regarding involuntary admission. You didn't say anything about the discharge either in the application to the court or in response to my objection or during conference and therefore, there is no court order -- the court order is limited to involuntary admission.

MR. SMITH: The second page of the involuntary admission policy talks about the second evaluation needing to be done under the Jamaica policy. So you're telling me I can't ask questions about the second assessment because the patient has already been admitted. Then I think we should really stop the examination and I will make my application.

MR. RADOMISLI: I'm not saying that you can't ask questions about the second evaluation. You can ask the

question you just asked.

MR. SMITH: Well, you don't get to decide that.

MR. RADOMISLI: No, the court does and the court order says involuntary admissions and that's what you noticed in your 30(b)(6) and that's what was subject of the court order is.

MR. SMITH: So you're splitting hairs and now you have it.

MR. RADOMISLI: Not splitting hairs. Going by exactly what you asked for.

Q. If the second doctor disagrees, what happens to the patient?

MR. LEE: Objection to the form.

MR. RADOMISLI: Disagrees with what?

MR. SMITH: The initial assessment.

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to the form, but you can answer it.

A. If the second physician

disagrees with opinion of the first physician, the second physician has to come up with his own opinion as to why he thinks the patient should or should not be kept in the hospital.

Q. Am I correct that if the staff psychiatrist disagrees with the assessment to keep the patient involuntarily in the hospital, the patient is not discharged?

MR. LEE: Objection.

MR. RADOMISLI: Objection to the form.

A. If the second physician disagrees with the diagnosis, then the physician has to come up with a reason for keeping the patient.

Q. And is that burden on the second physician based on a Jamaica policy statement?

A. Yes.

Q. Where is that statement?

A. It's part of the evaluation because the reason this is done is to make sure that all the information has been

received, that the collateral information, and all other information from other sources is also reviewed and then a decision is made after 48 hours.

Q. So you're telling me that the initial decision really isn't the final decision. That the final decision is really made once the staff psychiatrist makes the decision within the 48-hour period?

MR. RADOMISLI: Objection to form.

Q. Is that correct?

A. Yes.

MR. LEE: Objection.

Q. And you're telling me that the final decision by the staff psychiatrist is made after additional information is obtained from collateral sources?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to form.

A. Yes.

Q. What collateral sources is the information obtained from?

A. It could be anything, any family member, any agency, anywhere a patient can say that you can get the information from this source and whatever helps in making the assessment and decision of the patient.

Q. Are there any policy statements laid out in Jamaica Hospital for how an attending or staff psychiatrist makes this investigation into this collateral source information?

A. There's no specific policy, but there's practice that collateral information has to be obtained.

Q. And what is the practice about getting collateral information?

A. Any resources.

Q. Did you say any resources?

A. Any resources that the patient has that you can get information about the patient's condition.

Q. So is Jamaica policy for doctors to get any reasonable information that could be relevant to their decision?

A. Yes.

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Q. In the second page of the emergency admission status policy there is a paragraph number 4. It says that the admitting doctor is responsible for assuring the second examination is conducted within 48 hours. You see that?

A. Yes.

Q. How does the admitting doctor go about effectuating this policy of making sure the second evaluation is done within 48 hours?

A. The general practice is that when a patient is admitted, the admitting physician will inform the attending physician, who is receiving the patient, that this patient is being admitted and give information and then also based on any new patient that comes to the unit the time, the signature and the time on page 1 will determine what time the certification has to be made.

Q. So the date and the time is a pretty important entry in the patient's chart as to when they were involuntary

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admitted; is that right?

MR. RADOMISLI: Objection to form.

MR. LEE: Objection.

A. Yes.

Q. Does the Jamaica Hospital policy require that the admitting doctor consult verbally with the second physician or can it be done by simply having a file forwarded to the second physician?

A. General practice is to verbally inform the attending. Sometimes you don't know who the attending is going to be. So you give the report to the nurse. Nurse gives the report to the nurse on the unit and then they inform the doctor. If it's after-hours, in the morning.

Q. In that same paragraph of the policy statement it says that if the admission occurs during routine weekday hours, the admitting doctor will arrange for the psychiatrist who has admitting privileges to conduct the second examination immediately. You see that?

A. Yes.

Q. Why is it the policy of Jamaica Hospital to have that second evaluation done immediately?

A. I'm not sure why the policy is that.

Q. The last sentence says that any difficulty in making such arrangements is to be immediately referred to the chairman or one acting on his behalf. You see that?

A. Yes.

Q. Is the reference to the chairman is that Mr. Vivek -- Dr. Vivek?

A. Dr. Vivek, yes.

Q. And who are the individuals at Jamaica Hospital who would be acting on the chairman's behalf under this sentence?

A. That would be me.

Q. Have you been involved in making sure that the second evaluation happens immediately after the first one?

A. Yes.

Q. Is the reason why the second evaluation has to be done as soon as

possible after the first one, because the patient is being held against their will?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to form and asked and answered. Go ahead.

A. I guess, yes, that's the reason.

Q. Next paragraph number 5, there is a statement in the Jamaica Hospital policy to the effect that "should the patient reject this suggestion to convert to voluntary status and should the psychiatrist find that the patient does not meet the above criteria for emergency hospitalization, he must immediately contact the chairman or one acting on his behalf prior to the completion of page number 2 of OMH 474." You see that reference?

A. Yes.

Q. Is this the second -- no, that's a bad question. Let me rephrase that.

Why does the Jamaica Hospital policy provide that the psychiatrist should immediately contact the chairman or somebody acting on his behalf if he

disagrees with the initial assessment.

MR. LEE: Objection to the form of the question.

A. Because there are two physicians from the same institution in giving two different opinions. So it's responsibility of the chairman to make sure that the right decision is made.

Q. Is that responsibility of the chairman, is that laid out in, to your understanding, New York State Law 9.39?

A. I'm not sure.

Q. I gave you a copy of 9.39. Would you mind looking at it and tell me whether or not your understanding of this provision for having the chairman referee disagreements is part of the state law or not?

MR. RADOMISLI: Objection. He's not required to interpret the law.

MR. SMITH: I'm not asking for his interpretation of the law.

MR. RADOMISLI: You are.

MR. SMITH: No, I'm not. I'm

asking if he knows anything about the law.

MR. RADOMISLI: He answered that question.

MR. SMITH: More specifically, I want to know whether or not his function of the chairman refereeing disputes is, to his understanding, part of New York State Law.

MR. RADOMISLI: That's beyond the scope.

MR. SMITH: So you're going to direct him not to answer --

MR. RADOMISLI: I am going to direct him not to answer questions that requires him to interpret the law. That's correct.

Q. Doesn't your job as acting chairman of the psychiatric department at Jamaica Hospital require that you interpret 9.39 properly?

A. May job is to make sure that the clinical decisions are made properly.

Q. My question is don't you think

your job is to make sure that your staff is complying with 9.39 when they involuntarily commit people?

A. Yes.

Q. And in service of that objective, you have familiarized yourself with the statute, right?

A. Yes.

MR. SMITH: You're still going to instruct this witness not to answer those questions?

MR. RADOMISLI: He can answer that.

Q. Does the policy statement about having the chairman refereeing or be consulted by this psychiatric attending about a disagreement with the initial assessment comply with New York State Law, to your understanding?

MR. RADOMISLI: Objection to form. You can answer.

A. Say it again, can you repeat it?

Q. Yes. You have in front of you 9.39, right?

A. Yes.

Q. Is there a provision in the law, to your understanding, that provides that when the initial assessment and the second assessment disagrees that the chairman is to be consulted?

A. Every hospital has a departmental policy and a hospital policy because we're working under the hospital. So there's an internal policy to make sure that all decisions are made according to the law and based on the clinical decisions.

Q. This is my question, Doctor, I thought that the hospital policy was that you need to have a initial assessment confirmed by a second assessment as a precaution to protect the patient; is that right?

A. Yes.

Q. But the policy statement says that if there's a disagreement, the patient is not discharged, it says that there is a conferral with the chairman and what I want to know is whether or not you think that

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this practice or this policy of conferring with the chairman when there is a disagreement is consistent or inconsistent with your understanding of Section 9.39 of the Mental Hygiene Law.

MR. RADOMISLI: Objection to the form.

A. I won't be able to answer that question whether it's consistent with 9.39, but every hospital has an internal policy and we are required, the chairman has the responsibility of the entire department. He has to make sure that all decisions are made correctly and he delegates that authority to either me or the duty (phonetic) chief or the attending physician.

Q. Have you had occasion in the past as the acting chairman or the assistant chairman to act in this referee function?

MR. SMITH: Can you just hold that question a second. This is the court calling back I think.

Hello, oh, hi, yeah. This is Mr. Smith. Mr. Chan?

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CALLER: This is Adam Chen from Judge Sweet's Chambers. How are you doing?

MR. SMITH: I'm doing well. We're at the deposition and thank you for getting back to me and you're on speakerphone. All counsel and the witness and the court reporter are present.

CALLER: Okay. So I have instructions from the judge. He told me to let you guys know that all objections can be made, but there are no objections can be made not to answer except on grounds of privilege.

MR. SMITH: Okay. Thank you very much.

CALLER: No problem. Have a good day.

MR. SMITH: Okay, bye. Did you get that down?

All, right, I'm going to take a five-minute break.

MR. CALLAN: Yes. Just in terms

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of how much longer are we going to lunch break, break now or are we going to have lunch?

MR. SMITH: I just want five minutes to just regroup and see where I need to come back. This is unfortunately -- we are going to go off the record. It's 12:35.

(Whereupon, a recess was taken.)

MR. SMITH: Going on the record. It's 1:41.

Q. When we left off, Doctor, we were talking about this conferral with the chairman or the person acting on behalf of the chairman.

A. Yes.

Q. When the situation where the initial assessment gives a diagnosis and the second assessment has a disagreement about what that assessment is. That was the subject matter. Have you in the past ever acted as an intermediary for these types of situations?

A. Yes.

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Q. So what is the hospital policy with respect to how to address the disagreement between the initial assessment and the second assessment?

MR. RADOMISLI: Object to the form and substance, but you can answer.

A. Well, it's always been the customary practice of the hospital to get a second opinion, because it's a question of safety and we want to make sure that the right decision is made. And it has happened before.

Q. So do I understand you to be saying that the hospital policy will be to make sure that the second assessment is, in fact, correct?

A. If the second assessment is -- if there's a difference of opinion, then there will be a second opinion.

Q. Meaning third opinion actually?

A. A third opinion, yes -- well -- okay, a third opinion, yeah.

Q. And if the third opinion agrees with the first opinion, will a patient then

be maintained in an involuntary status?

A. If there is sufficient grounds and the person who is doing the third consultation or opinion will document that in their notes or write a new form.

Q. I'm not sure I asked the question clearly, so I am going to restate it. If the first assessment is the person should be involuntary comitted and attending psychiatrist says no, I don't think so, I think this person is either not suffering from a mental illness or has not demonstrated through words or conduct or some other means, dangerousness, and so I think the person should be released. Under those circumstances, the hospital practice and policy is to go to the chairman or somebody acting on behalf of the chairman, right?

A. Yes.

Q. And that chairman or that person acting on behalf of the chairman is another medical professional, right?

A. Yes.

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Q. And they will hear the pros and the cons about the two different opinions, right?

A. Exactly.

Q. What I want to know is if the third person to make this assessment agrees with the first assessment, that the person should be involuntarily committed, will the person be maintained in an involuntary status or will they be discharged?

MR. RADOMISLI: Objection to the form and has no connection to the case, but go ahead.

A. It's not an option of discharge, because you can keep a person on a voluntary commitment. So the option there is either to convert the involuntary to voluntary. The patient is willing to stay or yes, if the third opinion is that the patient should stay and we will keep the patient -- we may even go for the fourth opinion, because we are always acting for the safety of the patient. We would always -- err on the side of the safety.

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Q. When you say err on the side of safety, what you say is err on the side of maintaining them in the hospital against their will?

MR. RADOMISLI: Objection to form.

Q. Is that right?

MR. RADOMISLI: Objection to form.

A. Depending on the circumstances to what they came, safety if they are dangerous to themselves or others, yes.

Q. You recognize that dangerousness is an assessment about what somebody may do in the future, right?

A. No, actually, no. Dangerousness is what the patient came in for.

Q. So in order to make an assessment about whether or not somebody is dangerous, the medical professional has to look into the past, right?

A. Yes.

Q. So they're not trying -- they don't have a crystal ball and they're not

trying to look in the future to make a determination about what the person may do in the future; is that correct?

A. No. We try to see what the status is right now, what is the level of dangerousness right now, and whether there needs to be any treatment or any intervention until we find that the patient is safe to be discharged.

Q. So my understanding is you're saying that if, in the past, somebody had acted in a way that suggested that they were dangerous, but if they're no longer currently acting under those conditions, then everything else being equal, they would be considered not dangerous?

MR. RADOMISLI: According to hospital policy.

Q. According to hospital policy; is that correct?

A. Yes.

Q. So that the critical time for the initial decision under the 9.39, the condition of the patient at the time that

the comprehensive psychiatric evaluation is being done; is that correct?

A. Yes.

Q. You mentioned earlier today that there was in-service training, do you remember that?

A. Yes.

Q. What is that?

A. In-service training is you can say it's a class where the staff is updated on the hospital policy or the recent treatment changes or recent intervention. That is like giving training.

Q. Are there classes or training on making assessments about dangerousness?

A. Now, yes.

Q. Are those handouts or Power Point or some other form of communication?

MR. RADOMISLI: Objection to the extent that you're asking for currently, but given the judge's ruling, I have no choice but to let him answer the question.

Q. You can answer the question.

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THE WITNESS: I can?

MR. RADOMISLI: I am obligated to let you answer the question.

A. Yes, we do have. Now we have.

Q. When did Jamaica Hospital start having written presentations for in-service training on the issue of dangerousness?

MR. RADOMISLI: You're going beyond the scope.

MR. SMITH: No, I'm not at all. I'm trying to understand what the policy is, how the policy is effectuated, and how its intent is communicated to a physician that actually implements it, so I don't think I'm going beyond the scope.

MR. RADOMISLI: You could answer the question.

A. Could you repeat the question?

Q. I can't, but I will reformulate it.

When did Jamaica Hospital start having these in-service training sessions with the staff, where the subject matter of

dangerousness was taught?

A. When we have actually at Jamaica Hospital we have what's called grand rounds and case conferences. It started since 1995. We have two to three grand rounds a week.

MR. RADOMISLI: He asked you when. Read back the question, please.

A. We started earlier 1995, 1996.

Q. So if I went to Jamaica Hospital and I want to get a copy of this presentation, could I do that?

A. I don't know whether we used to keep any records of those at that time or not.

Q. Does Jamaica Hospital have any records today of what the training sessions look like over the past five years?

MR. RADOMISLI: Now I am going to object because one of the things that you asked to talk about was to have a witness testify on this issue and that was not permitted by the court.

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MR. SMITH: I don't remember that, frankly. All I am trying to do is find out -- I will make the request for the documents, if they exist, and I'm not going to ask the witness any more questions about the contents of these documents, but if they do exist and they had existed at the time, then I think you should produce them.

MR. RADOMISLI: Take that under advisement.

MR. SMITH: I'm just trying to establish if they exist.

MR. RADOMISLI: Then just -- you haven't asked that, do you know whether -- you didn't ask the when question. You skipped over that.

MR. SMITH: I did ask the when. I just didn't get an answer. I think the answer was since 1995.

MR. RADOMISLI: That was when --

Q. Let me ask you this question, in 2009 there were in-service training classes at Jamaica Hospital; is that right?

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A. Yes.

Q. In 2009 or as of 2009, those in-service training session included dangerousness assessment; is that right?

A. Yes.

Q. And those training sessions were, among other things, done verbally and in writing; is that correct?

MR. RADOMISLI: In 2009.

Q. In 2009?

A. Yes. I can recall verbally and not in the writing there is case presentation, a slight Power Point presentation.

MR. SMITH: So I am going to make a request for the production of any written presentations that were in effect and utilized as of the end of 2009 at Jamaica Hospital.

MR. RADOMISLI: Taken under advisement, please follow-up in writing, but it appears to me that this has come up and has already been ruled against and I'd appreciate that if I

show you that, then you'd agree to withdraw the demand.

MR. SMITH: If you can show me that the judge has considered this issue and rejected my request for that information and have also convinced me that no new information has come to light, which ought to make the judge reconsider that, if, in fact, he's taken that position and I will gladly withdraw it.

MR. RADOMISLI: I can show you where the judge considered it and not granted it.

MR. SMITH: Moving on.

Q. Now, earlier we talked about two ways that the individual is involuntary admitted to the hospital. You remember that generally?

A. Yes.

Q. Am I correct that there is a third way, which is commonly known as the CPEP way; is that a correct description?

A. CPEP?

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Q. Yeah.

A. How do you spell it?

Q. C-P-E-A -- not --

A. CPEP?

Q. CPEP?

A. Yeah.

Q. Okay. Maybe I'm just a little bit confused. There is the involuntary under 9.39, which we already talked about and then there was involuntary under 9.27, which is the two physicians involuntary and then is there is a third way known as this CPEP?

MR. RADOMISLI: CPEP.

Q. CPEP?

A. Comprehensive psychiatric emergency program.

Q. What is that?

MR. RADOMISLI: Going beyond the scope of the policy. It's not in there of --

MR. SMITH: I'm going to save you some breath.

Q. Was this CPEP program instituted

sometime after 2009?

A. Yes. It has been only for a year now.

Q. Only for one year at Jamaica Hospital?

A. Yes.

Q. If you don't mind, please turn back to 130 of the involuntary emergency admission status procedure. We were on page 18. Then bottom there is a number 6 and this relates to a request for a court hearing.

A. Yes.

Q. Can you describe for me what this policy is in number 6 about the request for a court hearing?

A. Every patient that is admitted on an involuntary basis has -- admitted to the inpatient unit, has access to mental health legal services. And if they wish to be discharged or the family wants, they want to discharge the patient, they will discuss with the doctor and if the physician disagrees with them and feels that the

patient is not ready for discharge, then if the patient or the family members can give in writing to the mental health legal service attorney, a notice that they wish to be discharged, they will file a petition and we will respond to that petition and within, I think within seven days or five days of, we will be going to the court in front of the judge, supreme court judge.

Q. Does the request to be discharged have to be given by the mental health legal services bureau or can it be given by the patient?

A. The patient gives it to the mental health legal services. He presents them. Or it could be their own attorneys.

Q. The paragraph that I am interested in, it says that if at any time after, it's after admission of the patient, a relative or a friend or the MHLS gives written notice to the director of a request for a court hearing, the director will immediately deliver to the Supreme Court of Queens County and to the mental health legal

services, a copy of the notice and a copy of patient records. That's what the policy statement says, right?

A. Yes.

Q. So do I understand the policy to permit the patient to give the notice required under this section to the physician?

A. I mean, according to the policy, yes, but it generally comes from -- the request generally comes from the attorney who starts the process.

Q. If a patient is in the in-patient ward or unit and the attending is talking with the patient and the patient says I don't think I belong here, I want to get out. Is that sufficient to trigger this policy for having the hospital petition the supreme court?

MR. RADOMISLI: Objection to form.

A. No, it's not sufficient.

Q. Why not?

A. Because based on the patient's

condition, depending on the diagnosis, patient can change their mind 24 hours a day. Generally, when a patient says something like that, you talk to them, you talk to the family and they will agree to take medication or not medication, unless we come up with a safe discharge plan, most patients stay back. They will not insist upon leaving, but at the same time we will ask them or tell the mental health legal service to please contact this patient, talk to him and see what he deserves -- what he wants.

Q. So the notice that's required to trigger this obligation on the part of the hospital to go to supreme court, this must be in writing?

A. Yes.

MR. RADOMISLI: Objection to form.

Q. It must be in writing?

A. Yes.

Q. Other than it being in writing, does it have to say anything or do anything?

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A. Well, it has to show the supreme court why the physician thinks medical necessity of the patient needs to stay in the hospital.

Q. No, I am talking about the patient. The patient's request to get out. This section 6 here, as I understand it, is a mechanism for involving the court, where a patient says I want to leave and the hospital says no, we think you should stay. So there's a disagreement, right?

A. Right.

Q. So this section provides a mechanism for petitioning the court to resolve the issue about whether or not the patient should kept against his or her will, right?

A. Right.

Q. What I want to know, it says here if at any time the patient or relative or the mental health legal services gives written notice, then this process starts. What I want to know is, other than this notice being in writing, is there anything

else about the notice that's required under this policy?

A. No, from the patient.

Q. So if a patient were to write on a piece of paper and hand it to his physician, I want to leave right now. That would be sufficient?

A. That would be sufficient as long as it's written, the notice will be process, yes.

Q. How long does the hospital take under this policy to petition the court?

A. As soon as possible.

Q. In your experience, what is that?

A. It's about a week, because court is only held on Tuesdays. So by Friday of that day if all the paperwork and everything is ready, the court hearing will be on Tuesday.

Q. Turn to the next page of the exhibit that you have in front of you. There's a admissions from emergency room policy statement.

A. 44?

Q. Yes, page 44. You have that in front of you?

A. Hmm-mm.

Q. What is this policy?

A. This is the protocol involved in transferring the patient or admitting the patient from emergency room under the inpatient unit.

Q. From the medical emergency room?

A. No. We're talking about from psychiatric emergency room to psychiatric inpatient unit.

Q. I see. So where it says here the policy a patient may be admitted from the emergency room to the psychiatric inpatient unit only after the evaluation in the emergency room by a member of the department of psychiatry?

A. Right.

Q. The references in that policy stating to the emergency room, are referring to psychiatric emergency room?

A. Psychiatric emergency room.

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Q. And this case, Jamaica Hospital has medical ER and a psychiatric ER; is that right?

A. That's right.

Q. And in 2009, that was also true, Jamaica Hospital had a medical ER and a psychiatric ER?

A. Yes.

Q. In the procedures it says each patient admitted to the psychiatric inpatient unit should have a medical clearance documented in the medical records by the emergency room staff. You see that?

A. Yes.

Q. Does that mean that all of the patient's medical records are taken from the psych ER and then sent up to the ward. Is that what this means?

A. Yes. I think what this means is that before admitting the patient to the psychiatric inpatient, we had to do what's called a medical clearance, meaning patient has to go on physical and medical clearance and that's done by a internist, not by a

psychiatrist or a primary care physician. And if they are medically stable and don't need any acute medical treatment, they will be admitted to psychiatric inpatient. Or they will be followed by medical attending.

Q. If a patient comes to the hospital through the medical ER --

A. Yes.

Q. -- unit and is there a policy in place for having a patient medically cleared by the medical ER unit before the patient is transferred to the psychiatric emergency room?

A. Yes.

Q. Why is that?

A. Because when a patient comes to the medical ER, that's considered as a medical emergency and before we transfer the patient to psychiatric ER, we want to make sure that they don't need any acute medical care.

Q. Does this policy that we are looking at right here, page 44, does this policy require that the records of the

documents in the medical records obtained when the patient goes into the medical ER that those records be transmitted to the psychiatric ER?

A. Yes.

Q. So in the circumstances when a patient comes into the hospital first through the medical emergency room, am I correct then that it's the policy to have that entire file sent to psychiatric emergency room?

A. Yes.

Q. And then in the procedures, there is a list of A, B, C and D. Do you see that?

A. Yes.

Q. There are these references to these tests CBC, CMP and any other blood test felt by the examining physician to be clinically indicated, you see that?

A. Yes.

Q. What is CMC and CMP?

A. CBC means basically your blood count, about the red cells and the white

cells any differential count. CMP means your comprehensive metabolic profile, means your liver enzymes, your kidney enzymes, your muscle enzymes, all comprehensive testing is done.

Q. Why is that done?

A. Because psychiatric patient who take medications, like any other medication, can have some side-effects and in order to make sure that there are no changes, so we need to have a baseline workup. So that if there are any changes we know that it's because of this treatment or this medication and also, to rule out any condition that has been silent there and patient not knowing. In our patients -- most of our patients don't take care of themselves. They are chronically sick patients. They don't care of their medical problems and that's why this provision was made that they would have a separate physical examination.

Q. On the next page is number 5, talks about the admitting psychiatrist will be responsible for determining that valid

legal papers are completed, what is that referring to?

A. That's referring to same form that we talked about, form 747.

Q. And it goes on to say "in the case of involuntary admission a licensed emergency room physician may act as a certifier." What is that a reference to?

A. It's the same thing that certifier in this emergency room will be admitting psychiatrist.

Q. Then the next paragraph says "the emergency room staff calls the inpatient unit for bed assignments."

A. Yes.

Q. What is that?

A. Well, when you admit the patient you need to have a bed on the inpatient unit. And so once you admit the patient, you need to know what bed patient will be assigned. They say the patient going to bed 204 because that bed is available right now. So the patient will be admitted to bed 204. You could see on the record there is

admitted to bed 204.

Q. Would that availability of a bed assignment have an impact on whether or not somebody is going to be admitted involuntarily to the hospital?

MR. RADOMISLI: Objection to form.

A. Yes.

Q. Why?

A. I'm jumping here. Because if we need to admit the patient on an involuntary basis, we have to have a bed available inpatient. If we don't have a bed, then we make arrangements for the patient to be transferred to some other hospital where beds are available.

Q. What other hospitals does Jamaica Hospital avail itself of to effectuate this practice or policy?

A. Well, we available all the hospitals in Queens. We call LIJ, Elmhurst Hospital, there used to be this hospital that's closed now and whatever hospital -- Gracey Square, we sent patients sometimes.

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Q. What about the availability of insurance, does that have any impact on whether or not a patient will be involuntarily admitted to the hospital?

MR. RADOMISLI: This is now beyond what's already been covered. So I am going to direct him not to answer.

MR. SMITH: The judge's ruling was very clear.

MR. RADOMISLI: Well -- doesn't mean it's beyond the scope of court order.

MR. SMITH: Well, I think the judge was very clear that no objections with instructions not to answer will be made except to preserve privilege.

MR. RADOMISLI: I'm sure he was not considering whether it would be within the scope of the EBT. I mean, there is still some basic parameters and that's what the -- what's the purpose -- that's what needs to be adhered to.

Q. Turn back to page 17, the

emergency admission status policy, there's a phrase substantial risk of physical harm. You see that?

A. Yes.

Q. How is that risk measured?

A. Like I mentioned before, there is no specific tools. It is measured based on the history available, circumstances patients coming to the emergency room and the collateral information.

Q. How does the hospital go about measuring whether or not the risk of physical harm is substantial?

MR. RADOMISLI: Objection to the form. You could answer.

A. It's not really defined. It's clinical judgment and based on that clinical judgment, you make a determination.

Q. Can a patient be held pursuant to this emergency status policy if the patient is acting bizarre?

A. Yes.

Q. Can a patient be involuntarily committed under this policy if they're

acting in an agitated manner?

MR. RADOMISLI: Objection to the form.

A. Any other conduct what's mentioned in the law based on the clinical judgment, any other behavior can be considered as a risk. Yes, patients can be put in the emergency room if they're agitated or they're acting bizarre.

Q. Is there anything more that is required, other than a label or the conclusion that the person is acting bizarre?

MR. RADOMISLI: Object to the form. Go ahead.

A. That is a sense of the evaluation that when a patient comes or the person comes, any definition by others, the admitting physician has to determine what does it mean by being bizarre and how does that impact the dangerousness of the patient.

Q. Can you define for me what kind of the behavior qualifies as bizarre

behavior that is sufficient to involuntarily commit somebody under this policy of Jamaica's?

MR. RADOMISLI: Objection to form.

A. I can give a number of examples. Patient is at home, locks himself up, threatens his mother or he goes out, takes his clothes off, runs around the neighborhood, stands in front of -- on the traffic light and starts preaching Bible and any -- or starts running around the traffic or highway, walking on the highway.

Q. Is it your view that all of that behavior would qualify somebody for involuntary commitment in the hospital?

MR. RADOMISLI: Under this policy?

Q. Under this policy?

MR. RADOMISLI: Objection to form.

A. Yes. Whatever called them to come to the hospital and then determination will be made whether they remain risk or

dangerousness. Then they will qualify for admission.

Q. I don't understand that answer. Can you explain that?

A. All patients that come with bizarre behavior doesn't necessarily qualify for inpatient hospitalization. If we determine that it's because of a mental illness or some emotional disturbance, then we can make assessment of patient being admitted to the hospital or in the absence of mental illness, if the behavior causes potential risk of harm to himself, then we can admit the patient.

Q. Is it a potential risk or is it a substantial risk that is required under the hospital's policy for involuntary --

A. Substantial risk. I'm sorry.

Q. It's a substantial risk; is that correct? So it's not sufficient if there is a potential risk, in other words to admit; isn't that right?

MR. RADOMISLI: Pursuant to the policy.

Q. Pursuant to the policy?

A. Substantial risk is to prevent the potential risk.

Q. My question is if you have a risk, but it's only a potential risk, is that sufficient to qualify as a substantial risk under the policy?

A. Under the policy, yes.

Q. So any risk is a substantial risk under the policy?

A. Under the policy for 9.39, yes.

Q. Why is that?

A. Safety.

Q. The safety of whom?

A. The person.

Q. What does the term substantial risk mean to you, Doctor?

A. It's a very undefined term that is used by different agencies by different professionals. There's a patient in the nursing home, there is a patient coming from -- patient living in the home by himself, he is -- has no food, has no heat, and if the neighbors complain that he's smelling. So

somebody will go there and make an assessment and if what they find there is potentially a dangerous situation, they will remove the patient and bring to the emergency room. So there is a substantial, as well as, potential.

Q. Isn't there a difference in your mind between any risk and substantial risk?

MR. RADOMISLI: I'm going to object to the extent you're asking for his mind. If you want to ask whether it's a policy --

MR. SMITH: Okay. Fine. I will ask what the policy is and see if he thinks there's any distinction either because we are mincing words here.

Q. Under the Jamaica Hospital policy, is there any difference between a potential or any potential risk of dangerousness and a substantial risk of dangerousness?

A. Again, it's a clinical judgment. I don't think it's defined in the policy.

Q. In your opinion, is there a

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difference between any potential risk and a substantial risk of dangerousness?

MR. RADOMISLI: He is here as a 30(b)(6) witness.

Q. Okay. You can answer the question.

MR. RADOMISLI: No, he can't.

MR. SMITH: You're instructing him not to answer that question?

MR. RADOMISLI: It's not proper of a 30(b)(6) witness. You know that.

MR. SMITH: No, I don't.

MR. RADOMISLI: I cited a case. Don't answer that question. It's not proper.

Q. Does the term substantial risk, as defined in the Jamaica Hospital policy, include any risk of harm?

A. Yes.

Q. So under Jamaica's policy, any possible risk is a sufficient basis in which to involuntary admit somebody, because of the conclusion that they are dangerous to themselves or others; is that correct?

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MR. RADOMISLI: Objection to the form.

A. Yes.

Q. Is part of Jamaica's policy in making this assessment about risk of dangerousness to seek out to protect the community, as well as, the patient?

A. Both.

Q. I'm sorry?

A. Both patient, as well as, the community.

Q. Why is the hospital involved in seeking out to make the community safe?

MR. RADOMISLI: Objection to form.

A. Because article 9.39 is safety for patient and others.

Q. So Jamaica Hospital views one of its roles under 9.39 is to make the community safe?

MR. RADOMISLI: Objection to form.

A. I don't think it's question of making the community safe. It's making --

actually, yes, it's a mental and as a patient rule in the Jamaica Hospital will not discharge the patient if we find out that the patient can be potentially risk of the community. Yes, we hold him.

Q. But you not only hold him, but you will admit him involuntary if you think there's a risk to the community, right?

MR. RADOMISLI: Objection to form.

A. Right.

Q. And you will do so even if you think there is only a potential risk to the community; is that right?

MR. RADOMISLI: Objection to form.

A. Yes.

Q. Is there a distinction in your mind between admitting a patient involuntary and committing a patient involuntarily?

MR. RADOMISLI: Objection.

A. Involuntary commitment is the legal term and admission is the medical term.

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Q. But the way we have been using it today, they both mean the same thing?

A. Same thing, yes.

Q. Does Jamaica's policy on the assessment of patients for dangerousness, include within it, a concept of hold and stabilize a patient?

A. Hold and admit. Not stabilize.

Q. What does that mean, hold and admit?

A. Hold, evaluate and if necessary, admit.

Q. Are you familiar with the phrase hold and stabilize?

A. There is, but emergency rooms are not meant for stabilizing. There is a timeframe and the volume and if I may add, that's why new CPEP came into being.

MR. RADOMISLI: You're talking about psychiatric?

THE WITNESS: I'm talking about psychiatric, yeah.

Q. Why did the CPEP come into play?

MR. RADOMISLI: Objection, but

he's already --

A. Because CPEP has a provision for 72-hour observation.

Q. What is that about?

MR. RADOMISLI: We are really getting beyond.

MR. SMITH: I know, but I'm trying to understand -- the phrase hold and stabilize was used in case with respect to this plaintiff. I am trying to understand whether or not that's part of the policy and practice of Jamaica Hospital.

MR. RADOMISLI: Can you just tell me where it was used 'cause it doesn't sound familiar to me?

MR. SMITH: You have the chart right there.

THE WITNESS: I can -- I can --

MR. RADOMISLI: Nat, I will talk to you outside.

MR. SMITH: Okay, good. We're going off the record. It's 2:28.

(Whereupon, a recess was taken.)

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MR. SMITH: Back on the record. It's 2:37.

Q. This term hold and stabilize, can you tell me what that means?

A. Well, actually it doesn't mean much. The term actually is hold and reevaluate. Some people use this term and I'm not familiar why they use this term. It's possible sometimes the patient can be treated within 24 hours or until all the information is available to make a final determination.

Q. Doesn't Jamaica Hospital's policy require that when a patient's brought in reportedly with a mental illness and reportedly engaging in conduct and making statements that create a substantial risk of physical harm, that a staff doctor conduct a comprehensive psychiatric as soon as possible, right?

MR. RADOMISLI: Objection, asked and answered.

A. Right.

Q. And there's no room in Jamaica

policy for holding a person for a period of time while an assessment is yet to be done; isn't that correct?

MR. RADOMISLI: Objection to the form. You could answer.

Q. You can answer.

MR. RADOMISLI: If you understand.

A. Yeah. Technically after 24 hours in the ER the standard of care, I don't think it's in the policy, that gives you time to make an evaluation and assessment and determination whether or not you want to admit the patient or discharge the patient.

Q. So this 24-hour period, you're saying there's no policy that's laying out a 24-hour period?

A. There is no time determination about that.

Q. So in 2009, there was no policy at the hospital that required that a patient brought in for an alleged mental illness be evaluated as soon as possible?

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MR. RADOMISLI: Objection to form.

A. As soon as possible.

Q. The policy was to do the evaluation as soon as possible, right?

A. Yeah.

Q. But earlier when I was asking you questions about the difference between a potential risk or any risk or substantial risk, I think you said if there's any risk that the patient would act in the dangerous manner that the hospital could admit; do you remember that?

MR. LEE: Objection to the form.

MR. RADOMISLI: Objection to the form.

Q. Do you remember that?

A. Yes.

Q. When you said, yes, it's possible for the hospital to the admit, did you mean that it was possible for the hospital to admit on an involuntary basis?

A. Yes.

Q. So just to be clear, you weren't

saying that the patient could be admitted on a voluntary basis when we were talking about doing assessments about dangerousness; is that right?

A. Yes. Only involuntary, yeah.

Q. When a patient is brought to the hospital as potential involuntary admission under 9.39, was there any policy at the hospital with respect to restraining that person or patient?

MR. RADOMISLI: Objection to the form.

A. Depends upon the circumstances, the patient is out of control and poses a danger to the staff, yelling, he will be restrained. Now there is a difference between restrained, a mental health restrained and restrained by other means. We do restrain the patients, yes.

Q. How does Jamaica restrain patients?

A. If patient is out of control according to OMH guideline, it's called a four point restrain. We tie the patient

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with the help of the staff, the clinical staff, and until make sure they are safe and meanwhile, they're given treatment, medication, counseling and then they are released and it should not last more than one hour.

MR. SMITH: I want to show you what's being marked as Exhibit 152.

(Plaintiff's Exhibit 152, document, was marked for identification as of this date.)

MR. SMITH: This is a seven-page policy statement produced by Jamaica Hospital in this case in discovery.

Q. Is this the Jamaica Hospital department of psychiatry policy on the use of restraints?

MR. RADOMISLI: Don't answer the question. You know this is beyond the scope. It wasn't even part of your application. This deposition is to deal with involuntary admission and this is beyond the scope.

Q. Is it consistent with the

hospital's policy to permit a patient to be handcuffed using steel handcuffs?

MR. RADOMISLI: Beyond the scope. You know it's beyond the scope. Don't answer the question.

Q. Is it consistent with the hospital's policy to double-cuff a patient to a hospital gurney?

MR. RADOMISLI: It's beyond the scope of the deposition and the court's order.

Q. When a patient is being assessed for involuntary admission, is it consistent or inconsistent with hospital policy to permit restraints to be used, such that, circulation of the patient is being interfered with?

MR. RADOMISLI: It is beyond the scope of the deposition, which is limited to policy on involuntary admission, per court order.

MR. SMITH: That's what I'm asking about.

Q. Can locked restraints ever be

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used on involuntary patients?

MR. RADOMISLI: Objection. Don't answer the question. It's beyond the scope according to the court.

MR. SMITH: Does not go beyond the scope.

MR. RADOMISLI: Has nothing to do with involuntary admission.

MR. SMITH: Just asking if it has to do with involuntary admission. I will ask it again, just so it's clear.

Q. Are the use of locked restraints consistent or inconsistent with Jamaica's policy with respect to involuntary admissions or people being considered for involuntary admissions to the hospital for dangerousness assessments?

MR. RADOMISLI: That's beyond the scope, because you're going to a policy other than a policy on involuntary commitment.

MR. SMITH: The judge has already directed you not to instruct

the witness not to answer questions, other than for privileged purposes and now you're vagrantly violating the judge's orders.

MR. RADOMISLI: It's not my intention to violate the judge's order. I don't think what was anticipated is that you abuse this deposition to go beyond what was a previously court ordered limited scope deposition, and actually, come to think of it, it's my position you're violating the prior court order by asking these questions because the scope of this examination was specifically limited to the policy on involuntary commitment -- involuntary hospitalization.

MR. SMITH: Well, I know. I understand, you've just said that. I don't think how what the policies of the hospital are -- you know, Greg, I will try one more time and this document that I have just shown this witness was produced by your office.

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It comes from the department of psychiatric. It says department of psychiatric, psychiatry manual and it's governing the use of restraints for patients who are there, among other things, involuntarily and so I don't know what else to say.

MR. RADOMISLI: I don't now what else to say either. I am not disputing that. You didn't ask for the witness to testify about this policy when it was discussed before the court, as far as I recall. If you did ask for it, it wasn't granted because there are only four topics that are permitted to ask this 30(b)(6) witness about. This is not one of those topics. The use of restraints is not one of those topics.

I'd also add that you already asked Dr. Lewin about this issue because she did her evaluation while your client was in the handcuffs, where I did not restrict you, because there was no prior court order. Here there

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is.

MR. SMITH: We are going to go off the record. I want to talk with my colleague and see how we're going to proceed. It's 14:50.

(Whereupon, a recess was taken.)

MR. SMITH: Going back on the record. It's 14:54.

Q. Doctor, I just have a few more questions then I'm done. Subject to having you brought back, because your counsel has interfered with some of my questions, but for today at least.

If a patient is brought into the medical emergency room, is there anything in the Jamaica Hospital policy that includes the comprehensive psychological evaluation being conducted while a patient is in the medical emergency room as opposed to waiting until the patient is the transferred, if the patient is transferred to the psychiatric emergency room?

MR. RADOMISLI: Objection to form.

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A. You cannot do a comprehensive evaluation. You can do what's called a psychiatric consult. That means based on the information and based on the mental status, you make a determination whether the patient will stay in the medical ER or he can be transferred to psych ER needing psychiatric treatment.

Q. Who makes that decision?

A. Psychiatrist.

Q. So why can't the psychiatrist do the full blown comprehensive psychiatric evaluation in the medical ER?

MR. RADOMISLI: Objection to form.

A. It's a comprehensive evaluation. Medical ER is very busy, don't have all the information and especially if there is a risk of dangerousness and if there is no need for medical treatment, then the patient will be transferred to psychiatry.

Q. Who does this consultation as opposed to this comprehensive psychiatric evaluation?

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A. It is done by a psychiatrist, a staff psychiatrist.

Q. Then does that consultation then trigger the 48-hour period and the requirements that the patient be given the notices and the rights that we talked about earlier?

A. No.

Q. Why not?

A. The 48 hours starts the minute the patient is admitted and registers in the psych ER.

Q. What authority is there in Jamaica's policies to hold somebody in the medical ER prior to a comprehensive psychiatric examination being conducted?

MR. RADOMISLI: Objection to form. Go ahead.

A. Because patient is kept in the medical emergency room only to make sure that there's no acute medical problems and necessity for discharge or medical -- or psychiatric treatment. That is the premise of the consultant. Based on the information

that the patient can be discharged, whether the patient doesn't have an acute illness or suffered some illness and there's a sense of dangerousness. Then that will be taken to the psychiatric emergency room.

Q. My question is what authority in Jamaica's policy is there, if there is any, to hold somebody against their will involuntarily in the medical ER before the comprehensive psychological evaluation is conducted?

MR. RADOMISLI: Objection to form.

A. They have the patient is -- until the patient is medically cleared, they will hold the patient.

Q. What I want to know is what authority does the hospital have for holding the patient under those circumstances?

MR. RADOMISLI: Objection.

A. I think medical ER policy.

Q. Is there a written policy that authorizes Jamaica Hospital to hold a patient pending a psychiatric consult?

A. Yes.

MR. RADOMISLI: Objection.

Q. And is that in writing, that policy?

A. It has to be, but if you look at 9.39 there is a provision there that any psych emergency room doctor can transfer the patient to psychiatric emergency room. Any medical emergency room physician can transfer patient to psychiatric emergency room per 939.

Q. But if that was done under Section 939, then Section 939 would have been invoked and the timeframes required by 939 would start running; isn't that right?

A. That's right, but the hospital policy is patient not to be -- until the patient is transferred to psychiatric emergency room, the 939 will start at that time.

Q. I understand that, Doctor. What I want to know, if the patient is brought into the medical ER and is being held against their will, but they have not been

evaluated by a psychiatrist, either in an informal consultation or a comprehensive, is there any authority in the hospital's written policies for holding that person against their will prior to them being assessed by a psychiatrist?

MR. RADOMISLI: Objection to form.

A. I am sure there is a policy. It again, depends on the clinical judgment of the medical ER doctor. If they feel that the patient needs to be restricted pending a psychiatric evaluation, they have that authority to keep the patient under observation.

MR. SMITH: I'm going to make the request for the production of that policy statement.

Q. What authority are you referring to?

MR. RADOMISLI: Objection to form.

A. The hospital -- I'm not sure about what authority the medical people

have, but there has been policy.

Q. Other than Section 9.39, are you aware of any other rule that allows a hospital to hold somebody against their will for purposes of an involuntary commitment for mental illness that has a substantial risk of dangerousness associated with it?

MR. RADOMISLI: Objection.

A. 939 is only for mental health. Emergency rooms, medical emergency rooms, have their own policy by department of health, DOH. So that will be covered under their jurisdiction. 939 starts only when a patient is transferred to psychiatric emergency room, which is the designated 939 hospital. Every hospital does not have a 939 room.

Q. In 2009, did Jamaica have a 939 room?

A. Yes.

Q. And a 939 room is a separate psychiatric emergency room, right?

A. Yes.

Q. And that's what it was in 2009,

correct?

A. Yes.

Q. In this case, the patient was brought into the hospital on late in the evening of October 31, 2009 and he was not evaluated by Dr. Bernier until November 2, 2009 and then the form was not executed by Dr. Bernier until November 3, 2009. What I want to know is during the period from when the patient was first brought into the hospital up until the point that Dr. Bernier signed the form 7 point -- 474, what was the authority that the hospital had for holding that patient?

MR. RADOMISLI: Objection.

A. I cannot answer.

Q. You can't answer it.

MR. SMITH: All right, subject to the questions that weren't answered, I don't have any more questions at this time. I am going to make an application to the court to have the witness brought back. The judge is away. We waited for more than a half

an hour to get a ruling the first time and so I'm not going to hold the deposition for that purpose now.

MR. RADOMISLI: Well, we did get a ruling and so if there are questions that you want to ask, other than the ones that I objected to on the ground that they were beyond the scope of the deposition, I suggest you ask them. Otherwise, they should not part of your application, because you have the opportunity now.

The only objections I would be asserting is if it's beyond the scope pursuant to a prior court order or under privilege.

So do you have anything that doesn't fall within that?

MR. SMITH: I don't have any more questions, other than the questions that you refused to let the witness answer and any rational follow-ups from the answers that he gave.

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MR. RADOMISLI: On the grounds -- refused to let the witness answer on the grounds that they were beyond the scope of the deposition. Correct.

MR. SMITH: Well, you've instructed him not to answer a lot of questions. I don't know if you were so clear about the scope, but I think we're on the same page here. If I had something else that was clearly not in an area that you and I had a disagreement about, I'd ask it, but nothing else comes mind.

MR. RADOMISLI: What I'm saying is if you want to make your application, you can make the application insofar as I objected to questions and didn't let him answer questions on the grounds that they were beyond the scope of the deposition. Any other objections that I may have made, I am not permitted to make pursuant to the court's order. So if there are any other questions, other

than the ones I objected to on the grounds of beyond the scope, those you have the opportunity to ask now and if you don't, then I am going to argue that they should not be part of your application.

MR. SMITH: Okay.

EXAMINATION BY

MR. CALLAN:

Q. Doctor, I represent Dr. Aldana-Bernier in this lawsuit. Can you tell me, sir, do you have a recollection back in November 2009, what your general work schedule was, what hours you'd be at the hospital?

A. Generally 8:30 to 4:30. I am on-call all the time.

Q. Do you get into the hospital on the weekends, as well as Monday to Friday?

A. I do come on the weekends if there is a need.

Q. And your position in the chain of command in psychiatry is you were the number two person; is that correct?

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A. Number two, right.

Q. So Dr. Aldana-Bernier would report to you in the chain of command?

A. She does report to me, yes.

Q. With respect to the Adrian Schoolcraft matter, I think you've said you had no involvement in the case; is that right?

A. I had no involvement in the case as far as legal proceedings and the treatment is concerned.

Q. Is it possible that you spoke to Dr. Aldana-Bernier about Adrian Schoolcraft at any time during his treatment in the psychiatric emergency room?

MR. SMITH: Objection to form.

Q. You could answer.

A. It's possible.

Q. Now, you made some general comments about comprehensive psychiatric evaluation of patients. Is it accurate to say, sir, that a comprehensive evaluation of a psychiatric patient would include reference to matters that may have happened

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in the initial admission stage to the medical emergency room, would that be part of the whole evaluation process?

A. Even before that. Certainly proceeding --

Q. So certainly anything that the ER residents became aware of, if noted in the record or communicated to the psychiatric staff, would certainly be considered, that could be considered in a comprehensive evaluation; is that correct, sir?

MR. SMITH: Objection.

Objection to form. Leading.

A. Yes.

Q. And if hypothetically, the police said something indicating that the patient was a threat to himself or somebody else, and I'm not just talking about Mr. Schoolcraft, I'm talking about patients in general, that would be something that would be considered in a comprehensive evaluation?

MR. SMITH: Objection. Leading.

A. Yes.

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MR. CALLAN: I have no further questions.

MR. LEE: I just have one.

EXAMINATION BY

MR. LEE:

Q. Under the Jamaica policy under 939, once the first doctor signs the form, that patient is admitted to the hospital, correct?

A. Yes.

MR. SMITH: You mean once the patient or once the doctor?

THE WITNESS: Patient doesn't sign any forms. The doctor.

Q. Once the first doctor signs the form under 9.39, even pending the 48-hour evaluation, once the first doctor signs, the patient is admitted to the hospital?

A. Yes. I mean, that form is signed only when the determination is made that the patient needs to be admitted.

MR. LEE: Thank you.

MR. SMITH: Just a follow-up on that.

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EXAMINATION BY

MR. SMITH:

Q. Is there any reason why a doctor at Jamaica would make a decision on one day and then delay signing the form until the next day?

MR. RADOMISLI: Objection, speculation, but go ahead.

A. When you make a decision that patient needs to be admitted on the psychiatric grounds, then you had to do all this blood work and everything else to get the medical clearance. So the actual admission date or time is different than when the doctor says that patient needs to be hospitalized, because all the other things are to be considered.

Q. I am not sure you're answering my question. My question is if the patient's assessment has been conducted and the comprehensive evaluation has been conducted and medical examination has been conducted, is there any reason why this staff psychiatrist in the psych ER would

wait a day when signing the form admitting the patient?

MR. RADOMISLI: Objection to the form and substance, but you can answer.

A. There are number of factors, yes. Availability of the bed. We don't know whether the patient admitted to Jamaica or transferred somewhere else and if the patient has insurance, we need to get the authorization approved for the insurance company.

Q. Any other reasons?

A. Not that I am aware of.

Q. In this case, the patient was a member of the police department. Are you aware of any practices or policies at Jamaica that requires that a involuntary admission of a police officer has to be reviewed by somebody else, other than the initial assessment conducted by the staff physician?

A. As far I am concerned, there is no such policy, the physician does clinical work and they do the determination.

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Q. Is there anything about a patient being a member of the police department that changes the hospital policy with respect to how an involuntary admission is conducted?

A. Absolutely not. There is relevance.

MR. SMITH: All right, thank you. Going off the record. It's 15:12.

(Time noted: 3:12 p.m.)

_____

VINOD DHAR, M.D.

Subscribed and sworn to before me this

_____day of _____2014.

_____, Notary Public.

I-N-D-E-X

E-X-H-I-B-I-T-S

ALL EXHIBITS RETAINED BY ATTORNEY

CERTIFICATE

I, DENISE ZIVKU, a Professional Reporter and Notary Public within and for the State of New York, do hereby certify:

That VINOD DHAR, M.D., the witness whose deposition is hereinbefore set forth, was duly sworn by me and that the within transcript is a true record of the testimony given by such witness.

I further certify that I am not related to any of the parties to this action by blood or marriage and that I am in no way interested in the outcome of this matter.

IN WITNESS WHEREOF, I have hereunto set my hand this 28th day of July, 2014.

DENISE ZIVKU

WITNESS'S CORRECTION SHEET

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VINOD DHAR, M.D.

Subscribed and sworn to before me

this _____ day of _____, 2014

_____, Notary Public.

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